



Plan International USA

Detailed Implementation Plan

for

**A Bundled Expanded Impact Program (EIP) for Cameroon
GHS-A-00-05-00015-00.**

With United States Private Voluntary Organizations

Helen Keller International and Population Services International

In partnership with

Ministry of Health, Cameroon

Association for the Self – Promotion of the East Province Population (AAPPEC), Saints

Stephen and Paul's Foundation (SPF),

Meta Cultural and Development Association (MECUDA), Project Hope – Cameroon

(PHC), Awaie Centre des Recherché (CR), ADEFKA,

Association for the Fight Against AIDS in Rural Areas (AFAARA),

GADES (Groupe des Acteurs du Progrès et du Bien Etre Social),

EMICAM, Ngoketunjia AIDS Fighters (NAFI), Kye-ele,

Association Camerounaise pour le Marketing Social

(Local affiliate of Population Services International)

And local communities

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Acronym List

AAPPEC	Association for the Self-Promotion of the East Province Population	CS	Child Survival
ADEFKA	Association pour le Développement des femmes du Kadeye	CSHGP	Child Survival and Health Grants Program
ACT	Artemesin Combination Therapy	CSSA	Child Survival Sustainability Assessment
AFAARA	Association for the Fight Against AIDS in Rural Areas	CSTS	Child Survival Technical Support Contract
ACMS	Association Camerounaise pour le Marketing Social	CSXVI	USAID-funded Child Survival Program 16 (2000-2004)
ACSD	Accelerated Child Survival Development	CV	Curriculum Vitae
AFP	Acute Flaccid Paralysis	DIP	Detailed Implementation Plan
ANC	Ante Natal Care	DHMT	District Health Management Team
ARI	Acute Respiratory Infection	DMO	District Medical Officer
BASICS	Basic Support for Institutionalizing Child Survival	DPT	Diphtheria-Pertussis-Tetanus
BCC	Behavior Change Communication	EIP	Expanded Impact Program
BCG	Bacille Camlet Guerin	EPC	EIP Planning Committee
CBO	Community Based Organizations	EPI	Expanded Program on Immunization
CCCD	Child-Centered Community Development	FE	Final Evaluation
CD	Country Director	GADES	Groupe des Acteurs du Progres du Bien Etre
CDD	Control of Diarrheal Disease	GOC	Government of Cameroon
CDTI	Community-Directed Treatment with Ivermectin	GUH	Growing Up Healthy
CHRP	Community Health Resource Persons	HA	Health Area
COGE	Health Area Management Committee	HACI	Hope for African Children Initiative
CORE	Child Survival and Collaborations and Resources Group	HAD	Health Action Day
COSA	Health Area Committee Members	HAHC	Health Area Health Committee
CPME	Corporate Planning, Monitoring and Evaluation	HD	Health District
CR	Centre des Recherche	HIA	Health Information Assistant
		HIDN	Office of Health, Infectious Disease and Nutrition
		HIPC	Highly Indebted Poor Country Initiative
		HIS	Health Information Systems
		HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno-Deficiency Syndrome

HKI	Helen Keller International	PD	Positive Deviance
HW	Health Worker	PHC	Provincial Health Coordinator
IEC	Information, Education and Communication	PHC	Project Hope Cameroon
IFA	Iron and Folic Acid	PIC	Provincial Implementation Committee
IH	International Headquarters	PP	Percentage Points
IHFA	Integrated Health Facility Assessments	PPM	Project Planning and Monitoring Module
IHC	Integrated Health Center	PRB	Population Reference Bureau
IMCI	Integrated Management of Childhood Illness	ProFam	ACMS-affiliated network of private clinics
INS	Institut National de la Statistique	PSI	Population Services International
IPT	Intermittent Presumptive Treatment	PVO	Private Voluntary Organizations
ITN	Insecticide Treated Net	RBM	Roll Back Malaria
KPC	Knowledge, Practice and Coverage Survey	RESA	Region of East and Southern Africa
LNGO	Local NGO	SA	Supervision Area
LOE	Level of Effort	SNEC	Société Nationale des Eaux du Cameroun
LQAS	Lot Quality Assurance Sampling	SP	Sulfadoxine Pyrimethamine
M&E	Monitoring and Evaluation	SPF	Saint Stephen and Paul's Foundation
MECUDA	Meta Cultural and Development Association	TA	Technical Assistance
MES	Monitoring and Evaluation Supervisor	TOT	Training of Trainers
MOH	Ministry of Health	TT	Tetanus Toxoid
MOST	Mobile Ongoing Sustainable Training	U5	Children under five years of age
MTE	Midterm Evaluation	UNESCO	United Nations Education, Scientific and Cultural Organization
NAFI	Ngoketunjia AIDS Fighters	UNICEF	United Nations Children's Fund
NID	National Immunization Day	USAID	United States Agency for International Development
NGOs	Non Governmental Organizations	VAC	Vitamin A Capsule
NNWG	National Nutrition Working Group	VAD	Vitamin A Deficiency
OPV	Oral Polio Vaccine	VAS	Vitamin A Supplementation
OR	Operations Research	WARP	West Africa Regional Program
ORS	Oral Re-hydration Salts	WARO	West Africa Regional Office
ORT	Oral Re-hydration Therapy	WHO	World Health Organization
OVC	Orphans and other Vulnerable Children	WRA	Women of Reproductive Age

A. Executive Summary

Location: The EIP is being implemented in 11 targeted districts in 3 provinces in the Republic of Cameroon. These are: Doume, Bertoua, Nguemendouka and Batouri in the East Province, Awae, Esse and Akonolinga in the Center Province, and Ndop, Fudong, Mbengwi and Bafut in the Northwest Province.

Problem Statement: 83,000 children die each year in Cameroon from preventable illness. Lack of child health information and access to quality care continue to hamper efforts to address the prevention and treatment of malaria, malnutrition, diarrheal disease and pneumonia. The Government of Cameroon (GOC) has planned to scale-up IMCI and RBM nationally to address these problems, but lacks the resources and human capacity to implement their plans. Plan, PSI and HKI will facilitate this scale-up effort by implementing an IMCI/RBM intervention that joins the efforts of the public and private sectors and the international development community, and by assisting the GOC in policy making and accomplishing national scale-up.

Beneficiaries: Direct beneficiaries of the program include 199,721 children U5 and 454,687 WRA in the 11 targeted districts. Of these children 44,363 are under 12 months, another 37,518 are between 12-23 months and 117, 840 are between 24-59 months. Indirect beneficiaries include 5,423,467 residents of the three program provinces who will benefit from better trained and supervised health care professionals, and 17 million citizens of Cameroon who will benefit from national efforts to: reduce malaria- and malnutrition-related mortality; increase access to affordable health supplies; and scale-up IMCI/RBM.

Program Goals, Objectives and Strategies, and Level of Effort: The Program goal is to accelerate the scale-up of IMCI/RBM in Cameroon, and to disseminate successful program interventions, through the concerted effort of organized communities and public, private and international institutions. The EIP seeks 3 main results: Improved Family behaviors and home care, Increased access to quality maternal and child health services and Improved capacity for public and private partners' systems and structures to sustain CS activities.

Level of Effort	Major strategies
Malaria (40%)	Promote preventive measures and the facility or home-based case management within 24 hours of the onset of symptoms. Facilitate Intermittent Preventive Treatment (IPT).
Nutrition (30%)	Promote exclusive breastfeeding and appropriate complementary feeding; facilitate the distribution vitamin A capsules to children 6-59 months and post-partum women and IFA to pregnant women. Nutrition education through Community Growth Monitoring and rehabilitation for malnourished children, including community-based PD/Hearth sessions.
Control of Diarrhea Disease (CDD) (10%)	Promote hand washing with soap, exclusive breastfeeding, vitamin A, safe excreta disposal and clean preparation of food; distribute water chlorination kits and ORS, promote administration of liquids plus ORT. Introduce zinc for the prevention and case management of diarrhea cases.
Pneumonia (10%)	Promote exclusive breastfeeding, appropriate complementary feeding, measles immunization as preventive measures, and early recognition and referral of suspected cases.
Immunization (10%)	Promote Facility and outreach based vaccination through rigorous assessment of the vaccination card during each visit. Link Immunization with exclusive Breastfeeding.

Operations Research and Documentation: In addition to HKI's operations research (OR) on the administration of zinc supplements during and after the diarrhea episode, the program will support small-scale operations research on the following topics: the use of low osmolarity ORS; and the community-based administration of IPT. Within the region, each partner is ready to expand program successes into their existing programming and future program design. Plan will disseminate lessons-learned to partners in the West Africa Regional Office through their annual meetings. PSI will put best practices on *The Wave*, PSI's internet-based best practices site for all country programs around the world. HKI will systematically post results of studies, lessons learned and best practices on the HKI web site and highlight particularly interesting results in the HKI Newsletter that is produced for all country offices. HKI will also disseminate selected information and materials via *Nutrition News for Africa* with an e-mail list of over 1000 health professionals throughout the world and summarized in three languages. At the US-level, Plan, PSI and HKI technical backstops will share information about the EIP with the CORE group.

Local Partners: ACMS (PSI's local affiliate), HKI, Plan and the MOH are the key partners for the EIP. Important local partners include 11 local NGOs, the University of Yaounde, World Health Organization (WHO), United Nations Children's Fund (UNICEF), private health providers and commercial outlets, and local communities. MOH will be responsible for facility level activities including staffing and supplies. They will also provide the coordination forum at the level of the Division of Family Health that brings together the IMCI Program, the EPI Program, the RH Program, and the Malaria Program. HKI will take the lead in the EIP Nutritional interventions including the promotion of Vitamin A and piloting the use of Zinc in the prevention and treatment of Diarrhea. ACMS will be responsible for promoting the correct use of health products like ITNs, Malaria Homecare kits, Chlorination kits and ORS. They will also oversee the communications component of the EIP interventions including the design and delivery of mass media communications activities. Plan will be responsible for community level activities within the 11 districts. Eleven local NGOs who have been working with Plan's community development program have been identified to work in the 11 districts as sub-grantees. Their major role will be to build capacity and facilitate existing Women's Groups, also called CBOs, and Health Committees at community level to reach and involve households in project activities. Regular Community Growth Monitoring conducted by the CBOs will be the vehicle used to recruit and involve beneficiaries.

Category of Application/Start and End Dates/Level of Funding/Name and Position of Mission Representative/Main Writers of Document/Contact Person at Plan:

The original application for the EIP was in the bundled/Expanded Impact category. The EIP program began on September 30, 2005 and will end September 29, 2010. The total budget is \$5,382,808. USAID provided \$4,000,000 and Plan, PSI and HKI has provided the \$1,382,808 match. The partners consulted Kristin Cooney and Seydou Dounbia of USAID West Africa Regional Program (WARP), and technical officers Naomi C. Fellows (Political and Economic Section) and Daniel Agoons (Special Projects Coordinator) of the United States Embassy to Cameroon. Kristin is the mission contact for this program. Main writers of the document include the project coordinator Dr. S. Atanga, ACMS deputy director Dr. J. Youmba, HKI Technical Officer Martin Nankap, Plan Cameroon Health Advisor Dr. E. Tallah, and Plan International backstop staff Dr. L. Tsuma, Pinar Polat and Dr. P.M. Metangmo. Contact person at PVO headquarters is Sam Worthington, Executive Director, Plan International USA, Inc.

B CSHGP Data Form

C. DIP Preparation and Project Start up Activities

DIP Preparation:

Event/ Meeting/ Dates/ Venue	Facilitator	Participants	Methods Used	Follow Up Activities/Agreements
DIP Workshop Planning 3/5/2006 Plan Country Office, Yaounde	Djibrila Boakay- Director MOH Family Health Cameroon	Director Family Health, RH Head and IMCI Head (MoH), Plan Country and US Staff, EIP Coordinator	Roundtable meeting to finalize DIP workshop timetable and assign moderators	Final Preparations for DIP Workshop Venue, Follow up with Secretary General of MOH who was to officially open Workshop
DIP workshop 3/6/2006- 3/8/2006 Hotel Azur, Yaounde	Pierre- Marie Metangmo	60+ members drawn from MOH (National, Provincial, District), Plan, ACMS (PSI), HKI, Project HOPE, 11 local NGOs, EIP staff, WHO and Community. USAID WARP, AWARE, UNICEF, US Embassy and University also invited	Through plenary and group discussions: -Highlights of the results of the baseline studies and implications to the EIP, -Status of project start up activities, -Review and negotiation of roles and responsibilities of various partners, - Agreements about coordination, RBA, creating national impact, HMIS and community involvement	Workshop documentation, adopted strategies for EIP program implementation, Program planning for the next 6 months, Sharing and informing about the EIP plans with USAID WARP, US Embassy, AWARE, University, Communities and others, Appointment of DIP writers
Writing Team Planning 3/9/2006 ACMS Office, Yaounde	Laban Tsuma, Pinar Polat	EIP staff, ACMS and HKI points of contact for the EIP, ACMS Communication s Officer, Plan US staff	Roundtable meeting to familiarize with FY 2006 DIP Guidelines, Assigning writing tasks and EIP activity planning, Agree on schedule for getting DIP sections ready	All writers to submit their work to the EIP coordinator by 3/24/2006. To have the 1 st draft of the DIP for review by 3/31/2006

Event/ Meeting/ Dates/ Venue	Facilitator	Participants	Methods Used	Follow Up Activities/Agreements
Debrief with CSTS 3/16/2006	Laban Tsuma	Michel Pacque, Jim Ricca	Telephone, Email	Agreement to share DIP draft for input before the 14 th of April
Debrief with US Embassy 3/23/2006	Pinar Polat, Shu Atanga, Martin Nankap, Jean- Christian Youmba	Met with 2 Officer in the US Embassy	This was a debrief	Concerns were raised about the introduction of more local NGOs and that this may be creating more layers between the project and the beneficiaries
Debrief with Faculty of Medicine and Biomedical Sciences, University of Yaoundé	Shu Atanga, Jean- Christian Youmba	Met with Dean of Faculty of Medicine and Biomedical Sciences, University of Yaoundé	Discussions	Agreement about the review of the student curriculum to embrace IMCI; Need to present proposal and highlight steps required
HQ (Plan,PSI, HKI) Backstops meeting on June 1, 2006	Temple Cooley, Erin Dusch, Laban Tsuma, Pierre- Marie Metangmo		Teleconference	Agreement on Responses to Reviewer Comments
DIP Review Meeting on 6/6/2006	CSHGP staff, other Mini- University participants	Mini- University Conference at the Homewood Campus of Johns Hopkins	Presentation and Discussions	Resubmission of Final DIP by July 15

Project Start Up Activities:

Event/ Meeting/ Dates/ Venue	Facilitator	Participants	Methods Used	Follow Up Activities/ Agreements
Meeting with USAID WARP and AWARE in Ghana August 2005	Pierre-Marie Metangmo	Kristin Cooney (USAID WARP), Ndong and Kone (AWARE)	Individual meetings	USAID and AWARE were very supportive of the EIP preparatory activities and requested updates
1 st National Stakeholder meeting 9/14/2005	Prem Shukla (Plan Cameroon Country Director)	Plan, HKI, ACMS, Pierre- Marie Metangmo	Roundtable Discussions	Agreed on timetable of activities leading to DIP writing.
2 nd National Stakeholder Meeting 10/4/2005	Prem Shukla	Plan, HKI, ACMS, Pierre- Marie Metangmo, Carole Andre	Roundtable Discussions	Discussed Coordination, Financial Management and Reporting Considerations between the partners
New Grantees Workshop 10/19/2005	CSHGP, CSTS	15 New Grantees including Plan	Plenary, Group Discussions, Q/A	Authority to incur expenditure given, Commission Baseline Surveys
Interview for EIP Coordinator/Approval by USAID 10/4/2005	Prem Shukla	Country Directors of Plan, HKI and ACMS, Pierre- Marie Metangmo	Interview	Joseph Shu Atanga was selected as the top candidate and approval for hire sought from USAID Washington.

Event/ Meeting/ Dates/ Venue	Facilitator	Participants	Methods Used	Follow Up Activities/ Agreements
Visit to The East Province CS XVI site (/25/2005-9/28/2005	Christopher Nfornyam- CS XVI Project Coordinator and now PU Manager Bertoua	Shu Atanga EIP Project Coordinator), Martin Nankap (HKI EIP Nutritionist), Jean-Christian Youmba (ACMS)	Site Visits to appreciate lessons Learned	Site Visit Documentation
Project Staff Hire October 2005-March 2006	Country Directors of Plan, HKI and ACMS	Human Resources Departments of the 3 organizations	Interviews and reference checks	Hire of all EIP staff in Plan, HKI and ACMS
Procurement Activities October 2005-March 2006	Procurement departments of the 3 PVOs	-	-	Sourcing for office furniture, vehicles, Motorcycles, desktop computers, Laptops, Printers
Official launching of EIP Project Hilton Hotel, Yaounde 11/23/2005	Alim Hayatou (MOH)- Secretary of State	US Embassy Technical Officer, Country Directors of Plan, HKI and ACMS, Pierre- Marie Metangmo	Official Launch and Cocktail	Partner Agreements were signed

Event/ Meeting/ Dates/ Venue	Facilitator	Participants	Methods Used	Follow Up Activities/ Agreements
LQAS TOT Workshop Bafut District 11/24-12/02/2005	Baburam Devkota, Pierre-Marie Metangmo	EIP Staff, Technical staff from Plan, HKI, ACMS. 11 DMOs from the 11 participating districts	11 day LQAS training, data collection and Analysis workshop in Bafut District	Analysis and Reporting of this survey was done and plans for district rollout of LQAS made
District LQAS Surveys 01/23-01/28/2006	Shu Atanga, 11 DMOs	EIP Staff, Technical staff from Plan, HKI, ACMS. MOH staff from the 11 participating districts	3 day training of surveyors and 3 day data collection in each of the 10 remaining districts	Analysis and Reporting
IHFA Surveys 01/12-01/18/2006	Shu Atanga, 11 DMOs, EIP Provincial Health Coordinators, Youmba Jean Christian	Government and Private Health Personnel	3 day training followed by data collection in selected facilities in each of the 3 provinces and the ProFam network	Analysis and Reporting
Qualitative Assessments (FGD, In-depth Interviews to DMOs and administration of OCAT to local NGOs 02/13-02/17/2006	Shu Atanga, Patrice Ndji	Mother's groups and CBOs in all the 11 districts, all District Medical Officers, 10 local NGOs	In depth interviews done with all 11 DMOs. FGDs done with Mothers groups. OCAT self administered by 10 local NGOs	Transcribing and Analysis. Reporting
Children's Consultations 02/13-02/17/2006	EIP Provincial Staff	School Children's groups in all the 11 districts	These were Focus group discussions and were taped	Transcribing and analysis. Reporting

Event/ Meeting/ Dates/ Venue	Facilitator	Participants	Methods Used	Follow Up Activities/ Agreements
Project Staff Training 11/8-11/10/2005, 12/12-12/23/2005, 3/1-3/4/2006	Human Resources (Orientation), Technical Staff (IMCI, LQAS, CSSA)	EIP Staff	All staff participated in Orientation and the CSSA training. EIP coordinator took 11-day IMCI course	Documentation
Child Survival Sustainability Assessment (CSSA) Framework Workshop 3/1/2006-3/4/2006	Laban Tsuma	40+ members from EIP, Staff from Plan, HKI, ACMS, 11 Local NGOs reps, Community Representatives, 11 DMOs and Plan Sierra Leone	Involved plenary, group work and case studies from Plan's experience in Kenya, Nepal and Mali	Developed Indicators for sustainability within 6 components and mapped out dashboards for 11 districts
DIP Workshop 3/6/2006-3/8/2006	Pierre-Marie Metangmo	60+ members drawn from EIP Staff, Staff from MOH, Plan, HKI, ACMS, 11 Local NGOs reps, Community Representatives, Others	See Above	See Above
Community Competence Workshop 3/9/2006	Ibrahim Kamara	EIP Staff, Staff from Plan, 11 Local NGOs reps, Community Representatives, 11 DMOs	Involved plenary, group work and case studies from plan's experience in Sierra-Leone	Forecast targets along 14 parameters for Community Competence in Malaria for each of the 11 districts

Key Highlights of the Project Start-Up Activities and the DIP Preparation Workshop

1. National stakeholder meetings

Plan Cameroon, ACMS and HKI held two main coordination meetings and a series of working sessions leading up to the DIP preparation. The meetings on 14/09/2005 and 04/10/2005 addressed coordination, planning, and financial management and reporting procedures.

2. Official launching of the EIP project

The official launching of the EIP project that took place on November 23, 2005 was presided over by the Secretary of State for public health, in the presence of the representative of the US ambassador to Cameroon and the three PVO country directors (Plan Cameroon, ACMS and HKI).

During this ceremony, the Country Director for Plan Cameroon, Prem Shukla, presented the lessons learned from the previous USAID funded CS project. Mr. Shukla outlined how the present project integrates lessons learned from the previous project thus enabling the project team and partners to reach more children in Cameroon.

Dr. Pierre Marie Metangmo, senior Health Program Coordinator at HQ discussed evolution of the project from the project development phase to its approval highlighting the project goals and objectives that are intended to support the MOH in scaling up integrated management of childhood illness (IMCI).

Representing the US embassy was the prime Technical Advisor to the US ambassador, who expressed approval and appreciation for USAID maintaining sustained input into community development in Cameroon. Citing the case of the CS XVI, the ongoing ITN project implemented by ACMS and the present EIP project, the representative explained that this sustained funding through the PVOs was as a result of the credibility that Plan Cameroon, ACMS and HKI maintained with the US government. He assured continuous support to the government of Cameroon through such PVO initiatives.

The Secretary of State for Public Health, Mr. Alim Hayatou, sitting in for the minister of public health formally launched the EIP and acknowledged the strong collaboration that exists between the MOH and the three PVOs (Plan Cameroon, ACMS and HKI) in different domains.

He concluded by urging other NGOs to emulate the example of Plan Cameroon and its partners in pursuing meaningful collaboration.

3. Staff Training

Staff training centered on four main aspects:

- A three-day centralized orientation workshop organized for the newly recruited EIP staff
- An 11-day training for the EIP coordinator on health facility IMCI
- Lot Quality Assurance Sampling (LQAS) methodology training for KPC baseline surveys
- Child Survival Sustainability Assessment framework

The increased capacity of the staff impacted positively on the output at baseline surveys and the DIP preparation.

4. DIP Start-up Workshop

The startup workshop facilitated by US technical back stoppers Pierre Marie Metangmo, Laban Tsuma, Carole Andre, Winnie Tay, Pinar Polat proceeded March 6-9, 2006 in Yaounde Hotel Azur. The workshop was attended by a cross section of the main implementing stakeholders including the MOH (central, provincial and district levels) the three PVO partners (Plan Cameroon, HKI and ACMS), local NGO partners and community representatives (see annex 3 for list of participants). It had as objectives to:

- Provide participants with essential project information and baseline results
- Update on national health policy aspects related to child health (IMCI, EPI Malaria etc.)
- Achieve agreement on partners' roles, responsibilities and commitment to working together as a team.

Generate ideas to address strategic implementation issues such as:

- Project co-ordination,
- Creating National Impact
- Project information management
- Operationalizing community based structures, and
- Rights based approach
- Develop planning milestones for major project's activities for the first year.
- Understand the overall CS project cycle and its integration into Plan Cameroon's existing programs and activities.
- During this three-day workshop the MOH partners presented government policy and focus areas of: the MOH 10 year health development plan, the national Malaria Control Program (RBM), the Expanded Program on Immunization (EPI), and the Integrated Management of Childhood Illness (IMCI).
- The presentation included an overview of how the EIP project (location, objectives, strategies and partners) linked with global Child Survival programming and integrated into the existing child and maternal health activities of Plan Cameroon. This was followed by the presentation of the EIP project baseline results and highlights of the major findings.
- The overview of the present health policy environment, the EIP project and the baseline results permitted the different stakeholders to determine their roles and responsibilities vis á vis the implementation of the project. Participants discussed specific issues related to implementation such as Project co-ordination, Creating National Impact, Information Management System, Operationalizing Community Based Structures and how best to adopt the Rights Based Approach.
- The outcomes derived from the workshop provided a solid foundation for the DIP writing phase.

Other project start-up activities

- The EIP identified 11 local NGOs as local partners for the implementation of the project. These local NGOs have an existing collaboration with Plan Cameroon and are all currently co-implementing at least one health project (HACI or CIMCI) with CBOs in the 11 health districts in partnership with of Plan Cameroon.
- The national EIP coordinator participated in the Plan RESA (Region for Eastern and Southern Africa) health net workshop themed “Scaling up Child Survival Best Practices” in Johannesburg October 31 through November 5, 2005. This was intended as an orientation to Plan as well as an opportunity to learn about health programming lessons from the region.
- The EIP coordinator and focal persons from ACMS and HKI visited the East province, site of the previous Plan CS XVI project, to directly observe lessons learned.

D. Revisions (from the original application)

	Section	Changes Made	Rationale
1	Goal and Objectives	Revision of Objectives	The Objectives were slightly revised to address the baseline survey results. The Percentage Point Increases were the most affected. Please see (i) below.
2	Beneficiary population	Increase of U5 and WRA	Population review revealed that the U5 population is 199,721 and not 190,985 as initially proposed. WRA population is 454,687 up from the proposed 244,036. This represents an increase of 8,736 U5 and 210,651 WRA or 219,387 beneficiaries.
3	Project Area	Increase in the number of Health Areas and Communities	While we did not add to or subtract from communities within the 11 intervention districts, a recent assessment of the actual number of Health Areas represented within these districts rose from 99 to 106 and the number of communities from 1000 to 1543.
4	Interventions	Addition of Immunization	Immunization coverage for children 12-23 months in some of the intervention districts was low (Akonolinga 30.4%, Batouri 37.5%, Doume 56% and Bertoua 57%). Please see (ii) below
5	Implementing Partners	Addition of 8 local NGOs	Assessment of the capacity of the initial 3 local NGOs revealed the need to focus one local NGO per district level for each district. Thus local NGOs partnering with the EIP was increased from 3 to 11.
6.	Budget	Budget Line Items	It was concluded that under budgeting for some line items such as Equipment (Motorcycles) and Staff Salaries/Benefits had occurred. This DIP addresses these issues and presents a revised budget.

(i) Amended Objectives

1. Decrease from 15.9 % to 7.9 % children age 0-23 months who are under-weight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population). Reduction of the Underweight index below 10% is multifactorial and

would depend on factors outside the scope of the EIP. We propose to revise the objective thus: **Decrease from 15.9 % to 10% children age 0-23 months that are under-weight.**

2. Increase from 50.8% to 90.8% children age 0-5 months who were exclusively breast-fed during the last 24 hours. Current prevalence of exclusive breastfeeding of children age 0-5 months is below 30% in Akonolinga and Batouri Health Districts. We propose to revise the objective thus: **Increase from 50.8% to 75.8% children age 0-5 months who were exclusively breast-fed during the last 24 hours.**
3. Increase from 92.1% to 112.1% children age 6-9 months who received breast-milk and complementary foods during the last 24 hours. We proposed to increase this objective by 20 PP but it is already high performing. DHS III 2004 showed that animal protein intake rate among children 6-9 months is 35.6% while vegetable protein intake rate is 20.4%. EIP baseline data shows that 65.3% of the children 6-9 months took animal and/or vegetable protein. We propose to revise the objective thus: **Increase from 92.1% to 95% children age 6-9 months who received breast-milk and complementary foods during the last 24 hours; Increase from 65.3% to 80% children age 6-9 months who received animal and/or vegetable protein during the last 24 hours.**
4. We propose to add this objective based on the baseline survey results which indicate Immunization coverage is a poorly performing indicator in the EIP districts. **Increase from 70.5% (EIP baseline data) to 80% children 0-23 who are fully vaccinated for all the recommended antigens.**
5. Increase from 11.8% to 61.8% children age 0-23 months that slept under an insecticide-treated net the previous night. The Abuja target for this objective due 2010 is 80%. We propose to revise the objective thus: **Increase from 11.8% to 60% children age 0-23 months that slept under an insecticide-treated net the previous night.**
6. Increase from 13.4% to 63.4% pregnant women who slept under an insecticide-treated net the previous night. The Abuja target for this objective due 2010 is 40%. We propose to revise the objective thus: **Increase from 13.4% to 60% pregnant women who slept under an insecticide-treated net the previous night.**
7. Increase from 7.7% to 57.7% mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated. This is a poorly performing indicator nationally and in order to be realistic we propose to revise it thus: **Increase from 7.7% to 35% mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.**
8. Increase from 65.9% to 105.9% mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment. We proposed to increase this objective by 40 PP, but it is presently high performing. We propose to revise the objective thus: **Increase from 65.9% to 80% mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment.**

9. Increase from 2.8% (DHS III 2004) to 27.8% women who completed Intermittent Presumptive Treatment (IPT) during their current or last pregnancy. We propose to revise the objective thus: **Increase from 2.8% to 75% women who completed Intermittent Presumptive Treatment (IPT) during their current or last pregnancy.**

(ii) Added Intervention

The national immunization coverage in Cameroon for 2004 for completely vaccinated children 12-23 month is 41.3% (DHS III 2004). In 2005, the EPI conducted a coverage survey and found that only 36.9% of children 12-23 months were completely vaccinated for all the antigens. The EIP KPC 2006 showed that 70.5% of 12-23 months are fully vaccinated against the vaccine preventable diseases.

EIP IHFA 2006 revealed the proportion of children who had a vaccination card checked at sick child visit to be 53% and that the proportion of mothers who had vaccination card checked at the time of sick child visit was only 6.4%. Also, the proportion of children who needed an immunization and who received it on the day of the visit or was referred for vaccination another day was 48%.

FGDs conducted during the EIP baseline survey reveal that cultural beliefs including “girl child infertility”, lack of access (geographical and financial), ill health of the child (fever) and ignorance in many communities are some of the reasons why care givers (parents) do not take their children for vaccination.

The present coverage of 70.5% is below the 80% objective of the MOH needed to break the transmission cycle of the vaccine preventable diseases. Based on these findings the EIP included immunization as one of its interventions.

E. Detailed Implementation Plan

1. Program Site Information

a) Location:

Cameroon is located in West Africa in the Gulf of Guinea. It is made up of ten administrative provinces, three of which are covered by the project. These three are the North West, the East and the Centre provinces. The three provinces are made up of 55 health districts, eleven of which are actual project intervention areas and distributed as follows: North West 4; East 4 and Center 3. The intervention districts are: Bafut, Ndop, Mbengwi and Fundong in the North West; Doume, Batouri and Nguelemendouka in the East; Esse, Awae and Akonolinga in the Center province. See maps in annex 2.

b) Estimated total population living in the project site.

Direct beneficiaries of the program include 199,721 children U5 and 454,687 WRA in three provinces, or 59% of the 1,108,981 total persons living in the 11 targeted health districts. The Indirect beneficiaries include 3,200,380 mothers and children resident in the three program provinces who will benefit from better trained and supervised health care professionals, and 16.5 million citizens of Cameroon (including 3 million children under five and 6.7 million WRA) who will benefit from national efforts through policy to: reduce malaria- and malnutrition-related mortality; increase access to affordable health supplies; and scale-up IMCI/RBM. The program staff will also reach out to the most vulnerable members of the beneficiary groups – persons living in absolute poverty, orphans and other vulnerable children (OVC) and their caretakers and people living in those supervision areas that score below the decision rule standard for specific indicators within health districts. The population breakdown for the children of age 0-5 years and the WRA is presented on the table below.

Province	Health District	Population	0-11 (4%)	12-23 (3.4%)	24-59 (10.6%)	<5 (18%)	WRA (41%)
East 890,325	BERTOUA	150702	6028	5094	16005	27127	61788
	DOUME	57989	2320	1959	6159	10438	23776
	NGUELEMIN DOUKA	39234	1570	1325	4168	7063	16086
	BATOURI	129025	5161	4361	13703	23225	52901
North West 2040555	BAFUT	83072	3323	2807	8823	14953	34060
	NDOP	212345	8494	7177	22551	38222	87062
	FUNDONG	195931	7838	6662	20868	35368	80332
	MBENGWI	75759	3031	2560	8046	13637	31062
Center 2,843,132	ESSE	30450	1218	1029	3234	5481	12485
	AWAE	36340	1454	1228	3860	6542	14900
	AKONOLING A	98134	3926	3316	10423	17665	40235
5,770,012		1,108,981	44,363	37,518	117,840	199,721	454,687

Program Activities by Location and Number of Beneficiaries			
Project location	National: All 10 provinces including 170 districts	Provincial: 3 provinces (East, Center & North-West) including 55 health districts	Health District: 11 districts of the 3 provinces (Doume, Bertoua, Nguelemendouka and Batouri in the East; Awae, Esse and Akonolinga in the Center; and Ndop, Fudong, Mbengwi and Bafut in the Northwest), ProFam clinics in Yaoundé
Interventions	National Working Groups, IMCI training, advocacy, internships, BCC, Lessons Dissemination	IMCI training, MOST unit, BCC	Facility-based IMCI/RBM, Community-based IMCI/RBM, Capacity building, Health days, BCC, access to health supplies, micronutrient supplementation
U5	3.0 million	976,735	199,721
WRA	6.7 million	2,223,645	454,687
Total Ben.	9.7 million	3,200,380	654,408

c. Discussion of the health status of the population including under-five and maternal mortality rates, nutritional status and major causes of mortality and morbidity.

According to the DHS III 2004, the under-five mortality rate was 144 deaths per 1000 and the infant mortality rate at 74 per 1000. In 2003, Cameroon ranked 26th among countries with the highest child mortality rates.ⁱ More than 83,000 children under five years of age die each year and most of these deaths are preventable. 40% of child mortality in Cameroon is attributed to malaria, with the remaining 60% of deaths almost equally divided between diarrheal diseases, pneumonia and neonatal conditions. The prevalence of cough with fast breathing, fever and diarrhea among the under five in the DHS 2004 were 11%, 24% and 16% respectively. Forty one percent of children 12 -23 months were fully immunized (DHS III cf. 70.5% in EIP KPC 2006). Only 12 % of under fives and pregnant women slept under an ITN the night before (EIP KPC 2006; 11.8 % and 15.7% for <5 and pregnant women respectively). Maternal Mortality Rate was reported as 669 per 100 000 live births (DHS III 2004) up from 430 per 100 000 live births (DHS II 1998).

Malaria is an endemic disease throughout the country and is the leading cause of morbidity and mortality. The main parasite is *Plasmodium falciparum*, which is carried by the *Anopheles* species of mosquitoes. The disease accounts for 50% of morbidity and 40% of mortality among under-five children. Intrauterine malaria causes nearly 10% of registered newborns to weigh less than 2500 grams at birth, placing them at the highest risk of death during infancy.ⁱⁱ The high vitamin A deficiency rates in Cameroon may contribute to malaria mortality. Ensuring vitamin A supplementation among all children 6-59 months of age and women post partum can reduce malaria associated mortality.ⁱⁱⁱ

In a 2001 survey, PSI found that almost seven out of ten rural respondents reported at least one episode of malaria in the preceding year; of these, 39% were reported to be children under the age of five. Approximately one third of respondents considered children under five at greatest risk, but only 9% mentioned the risk to pregnant women. In a 2005 survey, PSI found that 50% of rural respondents identified mosquito bites as the only mode of transmission. Other transmission modes reported included drinking dirty water and eating certain fruits, particularly mangoes. When asked how to avoid malaria, 91.6 % respondents considered it important to avoid mosquito bites. The same study revealed that of 91.3% of respondents who have heard about ITN, only about 18% slept under an ITN the previous night. The DHS III (2004) reported 3.1% of households in the North West province having at least one ITN. This indicator was 2.5 % for the East province and 1.2 % for the Centre province. Low birth-weight, often caused by intrauterine malaria, is a serious underlying cause of neonatal deaths.

About 18.0% U5 (DHS III 2004) are below appropriate weight for age. Malnutrition is an indirect cause in nearly 60% of all child deaths.^{iv} Vitamin A deficiency contributes to 23% of childhood mortality in Cameroon.^v The National Vitamin A Deficiency Survey, conducted in 2000 by the MOH, HKI, UNICEF and WHO, found a high prevalence of vitamin A deficiency (VAD) of 38.8%. Between 1991 and 2004 in Cameroon, the prevalence of stunting in children 0-35 months old increased from 23% to 32%, and the percentage of underweight children in this age group rose from 16% to 18%. As a result, the GOC has identified malnutrition as a priority health problem for children less than five years of age.

VAD among children 12-71 months Anemia prevalence and malnutrition among children U5 (DHSIII 2004)					
Province	VAD prevalence (children)	Anemia prevalence (children)	Proportion Children Stunted < -2z scores Height/ Age	Proportion children Wasting <-2z scores Weight/ Height	Proportion children underweight <-2z scores Weight/ Age
East	34.5%	73.2%	29.1%	2.4%	17.7%
Center	37.7%	73.5%	29.1%	3.5%	7.9%
Northwest	24.4%	54.7%	31.1%	7.8%	13.6%
National	38.8%	68.3%	31.7%	5.0%	18.1%

Anemia prevalence is high in Cameroon among pregnant women (45%; DHS III 2004).

Diarrhea, pneumonia and vaccine-preventable diseases are also common in Cameroon. 25% of children less than 5 years of age had one or more episodes of diarrhea in the preceding 2 weeks.^{vi} Seasonal changes that make water scarce in certain areas perpetuate

outbreaks of cholera, dysentery and other diarrheal disease during the dry season. The 2000 UNICEF Multiple Indicator Cluster Survey found that in the previous two-week period, 6.6% of children under five in the Northwest province experienced rapid or difficult breathing, while 9.4% of under-five children experienced these symptoms in the Center and East provinces. Immunization coverage for children is low at 70.5% with some districts such as Akonolinga at 30.4% and Batouri at 37.5% (EIP KPC 2006)

d. Description of other factors that influence health.

Socioeconomic factors related to health outcomes:

Political

Cameroonians generally work as subsistence farmers and petty traders. The population is divided between Moslems, Christians and those who hold Animist beliefs. Despite the multiplicity of tribes within Cameroon (there are 284), the cohesion between Cameroonians is evident and most of the literate population speaks both English and French.

The Western region, which is the predominant English-speaking region in Cameroon, is generally viewed as leaning towards the political opposition but this has not escalated to civil unrest. The region has strong social capital and, together with the South region, constitutes the breadbasket of Cameroon.

Poverty is a contributing factor to ill health among children. The under-five mortality rate is almost 200 per 10000 in the lowest income quintile in Cameroon, compared to 87 per 1000 in the highest income quintile.^{vii} Gross National Income per capita is less than \$640 per year.^{viii} 70% of the rural population lives below the poverty line.^{ix} A poor family's annual spending on health care averages \$17.89, \$9.55, and \$16.69 USD in the Center, East and Northwest provinces, respectively.^x With these incomes and expenditures, many poor families are unable to pay for services at health facilities and therefore do not take their children in when they are sick. Only 20% of the Cameroonian population regularly accesses health facilities. Furthermore, when caretakers do take children to the health facility, many are unable to purchase the prescribed medication to complete the recommended treatment.^{xi}

Geographical access to health care is limited for Cameroonians, and the cost of transport is a significant barrier for the poor. The average distance that a family has to travel to a public or private health facility is 7.8 km in the Center Province, 6.1 km in the East Province and 5.6 km in the Northwest Province.^{xii} While 50% of the general Cameroonian population lives within the 5km radius of a health facility, impoverished citizens in the project area live in sparsely settled communities and may be far from their local health facility.

Cultural Factors: Cultural beliefs influence breastfeeding practices. For example, newborns are not fed on colostrum due to a perception that it is unclean. Furthermore, a mother who has commenced sexual activity (a term locally known as crossing over) soon after birth immediately terminates breastfeeding based on a belief that the breast milk has been spoiled by the sexual activity. Exclusive breastfeeding is around 1% (EIP KPC 2006)

because mixed feeding is the norm from birth. Many young women in the project area feel that they have to choose between traditional cultural practices promoted by their mothers-in-law or 'grandmothers' and modern practices. This limits their adoption of positive health behaviors. Plan has found, however, that grandmothers who are informed participants in the community health structures have a very positive effect on younger mothers. For example, several young mothers who had not participated in health education activities testified during the final evaluation of the CSXVI project that they learned many positive attitudes and behaviors from trained grandmothers, including exclusive breastfeeding for the first six months and vaccinating their children following the immunization schedule.^{xiii}

Status of Women

Female literacy is high at 92% in the North West, 89.2% in the East and 86.2% in the Center Provinces (DHS III). The status of women has been generally low in the past but has recently received a boost due to the dynamism of the First Lady of Cameroon, Mme.Chantal Biya, who has publicized the central role of women in Cameroon. The Annual Women's day is an annual event held with the gusto and fervor of a holy day in Cameroon.

e. Current status and overall quality of health care services in the site

Health Care Services

Government health strategy for Child Health: IMCI is a service delivery strategy in its early stage of implementation in Cameroon. The MOH created an IMCI Unit and adopted an IMCI policy in the late 1990s. The National IMCI Working Group, comprising public and private institutions including UNICEF, WHO and Plan Cameroon, supported these efforts. In the initial steps (2002-2003), 10 national IMCI facilitators, including some University faculty, were trained overseas and the MOH and NGO partners developed locally-appropriate IMCI materials. The MOH selected three health districts in 2002 as pilot sites for IMCI implementation. Each site was financially and technically supported by an international organization: Plan supported Doume District in the East Province (CSXVI project site); UNICEF supported Ngaoundere Rural District in the Adamaoua Province; and WHO supported Eseka District in the Littoral Province. In March 2005 an End Term Evaluation of the Pilot Phase was done and the MOH commissioned the scale up of IMCI. As IMCI scales up in the country, the Faculty of Medicine and Biomedical Sciences of the University of Cameroon are interested in including IMCI in their curricula.

Currently, the government has created a budget line for IMCI of USD \$40,000 and has also assigned USD \$400,000 from the Highly Indebted Poor Country (HIPC) initiative for IMCI use. However, these funds have not yet been disbursed throughout the MOH health system. With this financial support and international cooperation, the MOH aims to have 50% of health districts implementing IMCI by 2008.^{xiv}

Government health facilities and community participation: The MOH health system comprises three levels. The central level sets policy and mobilizes resources; the provincial level brings technical support to reinforce district-level health care; and the

districts implement health interventions. According to the reorientation of primary health care of 1999, the MOH has divided the country into 170 Health Districts. Each Health District is made up of Health Areas. While a Health District is served by a district hospital staffed with teams of medical and/or nursing professionals, a Health Area is served by an Integrated Health Center (IHC) usually staffed by only one nurse or a nurse assistant and occasionally by a laboratory technician.

Public health personnel are often poorly paid, poorly trained and unmotivated. Routine turnover of MOH staff every few years negatively affects the sustainability of training efforts as trainees leave for posts in other areas. In many districts, an inadequate technical quality of care coupled with poor provider-client communication constitutes significant barriers to care seeking and leaves clients unsatisfied when they do access health services. Only 50 % of the poor who attended an IHC in the Center and Eastern Provinces were satisfied with the care provided, while 73% of those accessing IHC services were satisfied in the North West province.^{xv}

During the 1999 reorientation, the MOH promoted a dialogue structure within the Health Areas to facilitate community participation. This structure is comprised of 2-3 representatives elected by each community, village or neighborhood in the catchment area. Their role is to identify relevant health issues in the community, support outreach activities and to serve on the Health Area Health Committee (HAHC or COSA). The HAHC/COSA members meet every 3 months to discuss health issues in the area and to explore potential solutions.

The HAHC members select a few of their members to constitute the Health Area Management Committee (HAMC or COGE). The HAMC/COGE members meet monthly to discuss management and administrative aspects of the IHC, namely the revolving drug fund for the IHC's pharmacy and the other cost recovery activities of the IHC and budget planning. Through the IHC revolving drug fund, the GOC has created an essential drug supply system through CENAME (National Drug Procurement Center) that provides generic versions of essential medications. This reform has greatly reduced the cost of medication to community members. However, supervision of the pharmacies is limited by a lack of transportation and few communities know that they can hold the health center pharmacy accountable for maintaining the generic drug supply.

One important challenge within both the COSAs and the COGEs is the gender bias in their memberships. While both are comprised mostly of men, the adult clients of the IHC are primarily women.

The private health care sector: Per capita health spending in Cameroon totals \$24 USD per year. Households provide nearly 75% of these costs as out of pocket expenses while purchasing goods or services from the private sector. Faith-based health facilities are integrated with the MOH and have additional resources from outside donors. In the program districts, health facilities are primarily Catholic, Presbyterian and Baptist. Private clinics and local NGOs also provide health services. These include Mutcare in the East province, CAMNAFAW for family planning in the Northwest province, FAS Foundation for HIV/AIDS prevention in the Northwest province, and Sight Savers, also in the Northwest province. Plan has partnered with the only US PVOs conducting health programming in the three provinces: PSI/ACMS and HKI.

In addition to religious and secular health facilities, the poor usually depend on traditional healers or occasional itinerant drug vendors for their health care. Faith in traditional healers is fueled by the common belief that certain illnesses are linked to witchcraft and

that certain illnesses, such as jaundice, cannot be treated at the hospital. Traditional healers are often consulted first and health facilities are visited only when traditional remedies fail. Drug vendors frequently sell low quality products and provide poor counseling. While drug vendors and traditional healers have the trust of the population, they often disparage "Western" medicine and cause delays in care seeking. Many areas do not have consistent MOH outreach services to provide the population with basic, accurate information on child illness.

Table outlining resources per sub-area

Government, Private and Mission-run health services and staff in the 11 districts of the EIP

Program Areas	East Program Area				Centre Program Area			Northwest Program Area				TOTAL
Health Districts	Doume	Bertoua	Nguelem endouka	Batouri	Awa e	Esse	Akonoli nga	Ndop	Fundong	Mbengwi	Bafut	11
# of Health Areas	6	16	4	13	4	6	11	14	11	12	9	106
# of Communities	129	145	62	242	84	134	384	63	80	92	128	1543
# of Doctors	1	3	2	7	1	2	3	5	11	3	3	41
# of Midwives	2	3	0	4	1	0	2	9	14	6	7	48
State Registered Nurses	8	6	3	7	4	3	8	8	23	16	14	100
Nurses with diploma	15	24	12	41	5	10	41	34	114	11	30	337
Other (lab technicians, community pharmacy worker, volunteers)	6	8	4	15	7	3	12	19	20	12	7	113
Total health personnel	32	44	21	74	18	18	66	75	182	48	61	639

f. Groups in the program site that are considered disadvantaged, at high risk of death, under-served or living in extreme poverty.

The Baka and the Mbororo ethnic groups are marginalized groups that will require special outreach to benefit from EIP activities. Plan's existing relationship and established trust with the Baka population will enable EIP to extend health information and outreach. Another disadvantaged group is the caretakers of orphaned and vulnerable children and others living in extreme poverty. Through HACI, the EIP will reach out to these beneficiaries through intensified health promotion and follow-up by community health volunteers, NGO field workers, and private-and MOH-health facility staff.

g. Linkages and Complementary Activities

The Ministry of Public Health has embarked on free ITN distribution to children under five and pregnant women nation wide. These freely distributed nets are not enough and the distribution is difficult to manage. Through a grant from Plan's France National Office, Plan Cameroon is currently implementing a 3-year free ITN distribution project in one health district (Akonolinga) in the Center Province. ACMS has been doing social marketing for ITNs in the whole country and intends to intensify this aspect within EIP's 11 health districts. The project will intensify beneficiary awareness on the importance of ITN acquisition and use.

Plan Cameroon is operating under a 10-year Country Strategic Plan in 12 districts (including all the 11 EIP districts) which focuses on Maternal Health and Child Survival, Food Security and Poverty Alleviation, Pygmy Rights and Dignity, Quality Basic Education, and Child Rights Promotion. Through a grant from Plan's Netherlands National Office, Plan Cameroon has introduced community IMCI and PD/Hearth in the 11 health districts that runs from 2004 to 2007. Through another grant from Plan's France National Office, Plan Cameroon has an ITN program in Akonolinga Health District from 2005 to 2008. The EIP will build on the lessons learnt from these projects in the implementation of its interventions. In addition, many of Plan's other existing activities directly contribute to the goals of the EIP, such as School Health Promotion under the Quality Basic Education program and Participatory Hygiene and Sanitation Transformation program.

In neighboring Adamoua Province, UNICEF is implementing Accelerated Child Survival and Development (ACSD), which technically focuses on utilizing routine services to provide Vitamin A, ITNs and IPT to children under 5 and pregnant women. This provides opportunities with EIP to share lessons learned and to disseminate and replicate experiences to a wider beneficiary group in Cameroon.

2. Summary of Baseline and Other Assessments

a. Types and methodology of baseline assessments conducted

The baseline survey was multifaceted and collected a wide range of data using conventional methodologies. A desk review of the DHS III 2004 and various other data sources within the GOC Health System was carried out. The partners decided to complement this information with extra studies. Community or household quantitative data (KPC) was collected using the LQAS methodology. Health care delivery and quality of care at the level of the health facility was assessed using the Integrated Health Facility Assessment (IHFA) tool developed by BASICS. Focus Group Discussions (FGD) were conducted with caregivers and community-based organizations and school children aged 5 to 10 years of age. The topic guides used for these discussions were adapted from the KPC 2000+ toolkit and relate to findings from that KPC survey that required further elaboration. In depth interviews were carried out with the DMOs from all the 11 districts. An Organizational Capacity Assessment was conducted for the 11 local NGOs earmarked as local implementing partners in the EIP. The OCA tool developed by PACT was used. Finally, the Child Survival Sustainability Assessment (CSSA) framework was applied with all project stakeholders to evaluate the sustainability profile of each health district based on 6 determinants (components) which include health outcomes, health services, organizational capacity, organizational viability, community competence and the environment.

A) LQAS: Rationale for LQAS and Parallel Samples

Within the EIP, numerous discussions with stakeholders tried to establish the best strategies for assessing baseline values for key Child Health Indicators in each of the 11 districts.

The project opted to use the LQAS methodology to assess the Knowledge Practice and Coverage of the community target groups. This was because the LQAS can both assess the average coverage of a particular indicator within the entire project area while also indicating with close accuracy whether a project sub-area or supervision area is above or below the average coverage for a particular indicator. This allows for LQAS to guide management in how to allocate resources due to knowledge of:

- How a supervision area is faring for a particular indicator
- Which indicators within a supervision area are doing well and which are not
- How supervision areas within a program area compare with one another.

The LQAS methodology uses small random samples of 19 from every lot to provide information about the prevalence of a particular indicator. The recent LQAS manual has recommended a minimum sample size of 95 to estimate a coverage proportion for the entire project area. This means that prevalence of a specific indicator in an area comprising a minimum of 5 lots from which a sample of 19 has been picked out randomly from every lot (giving a total of $19 \times 5 = 95$) is as accurate as that given through other methodologies with sample sizes greater than 95.

The reason why LQAS uses a sample of 19 for each lot is that any sample that is less than 19 will have alpha or beta errors, for incorrect assessment of lots, greater than 10%. In keeping the lot sample size no less than 19 the margin of error is less than 10%, consistent with statistical convention. Similarly, increasing the lot sample size creates more work but does not necessarily reduce the number of lots that would be incorrectly assessed by the methodology.

Alpha and beta errors indicate how often your judgment will be wrong about a lot or supervision area that has reached performance benchmark.

An important decision made in EIP baseline survey in the 11 health districts was how to define a lot or supervision area. The MOH District health service is composed of Health Areas as units of supervision. In some health districts, these units are as many as 20 and in others they are as few as 4. For practical purposes and in conformity with the LQAS methodology that requires not less than 5 “Supervision Areas” to obtain a standard sample size of $19 \times 5 = 95$, the Evaluation Task Force mapped out health districts into 5 lots each. This was done by merging some Health Areas and/or by splitting large Health Areas.

In KPC 30-cluster sampling, a single client universe comprising mothers of children age 0-23 months is usually targeted. With a total sample of 300, the denominator for the calculation of each indicator is usually big enough to give a statistically valid result. The challenge with the LQAS sample is that a random lot sample of 19 from a similar client universe (Mothers of children age 0-23 months) may not yield the required lot denominator of 19 in order to calculate indicators that are specified by age of the child e.g. Exclusive Breastfeeding Rate (EBR) which requires mothers of children age 0-5 months. To work around this challenge, and to ensure that data is collected from 19 mothers of children age 0-5 months in every lot, several age specific indicators within the EIP were identified.

This discussion led to the definition of 5 specific client universes that would have to be reached within every lot to provide the necessary information required. These were:

- I. Mothers of children age 0-23 months
- II. Mothers of children age 0-5 months
- III. Mothers of children age 6-9 months
- IV. Mothers of children age 12-23 months
- V. Mothers of children age 6-59 months

A specific questionnaire was developed for each client universe (Annex 4). Questionnaire I was the lengthiest. Questionnaires II to V were short as they included a few questions to provide information for a specific indicator.

Because of the relative overlap between these client universes some respondents responded to multiple questionnaires because they qualified for the multiple categories. For example a mother with a 7-month-old child qualified and was requested to respond to Questionnaire I, III and V.

Each of the five supervision areas in each of the health districts listed all their villages and population located within its service jurisdiction. A cumulative total of the population was determined and a sampling interval calculated by dividing this total by 19. An LQAS sample of 19 respondents, for each of the 5 client universes, was sampled from each Supervision Area. Larger villages had greater probability of being chosen as sites where respondents would be randomly picked. Hand drawn maps were used within a specified village to randomly pick the appropriate respondent.

LQAS Training, Questionnaire Development, Data Collection and Analysis

A trainer of trainer workshop was organized in the Bafut Health District, consisting of EIP staff, staff from Plan's regular program, MoH, ACMS, HKI and local partners. The participants were drawn from the entire EIP project area and represented all 11 districts. Babu Ram Devkota, a consultant, was identified to lead the process. This was vital because the Bafut training and the consequent LQAS exercise was an early TOT effort that would lead to training and implementation of LQAS in the remaining 10 districts by the trainees. A total of 5605 Questionnaire responses were received from the Nine Supervision Areas used in Bafut and the 50 Supervision Areas in the other 10 districts. Epi Info 2000 was used for data analysis.

B) Integrated Health Facility Assessment (IHFA)

IHFA was carried out in each of the 11 districts under the leadership of the provincial EIP team with supervision from the EIP central team. A total of 76 Health Facilities were sampled within the 11 districts and another 25 ProFam facilities within Yaounde. While all the ProFam Clinics in Yaounde were private, those within the 11 districts comprised a mix of MOH, Private, NGO and Mission Facilities. At each provincial level, the EIP team, in collaboration with the MOH, recruited and trained a mobile survey team that went across the districts to collect data from sampled health facilities using the adapted standard BASICS toolkit. A total of 23 three-man teams each comprising 2 surveyors and one supervisor comprised these mobile teams. Twenty-nine facilities and 183 children were surveyed in the 4 districts of North West Province while 26 facilities and 92 children were surveyed in the 4 districts of the East Province. Twenty-one facilities and 57 children were surveyed in the 3 districts of the Center Province. 105 children were seen in the 25 ProFam clinics.

The BASICS toolkit was adapted for local use according to national GOC guidelines and the requirements of the EIP project. Adaptation was done in close collaboration with MOH staff and EIP partners. For French speaking areas like Center and East Province the adapted tools were applied in French.

Five questionnaires were used for assessing the different areas of care (Annex 4). These were

- I. Health Care Provider Observation of Practice
- II. Exit interview of caregivers to assess communication and comprehension of messages

- III. Interview with the head of the health facility to assess the system
- IV. A Checklist to assess health facility supplies and equipment
- V. A tool to assess existing linkages between the health facility and community.

On arrival at the health facility, the health worker who was normally responsible for seeing sick children was identified. If more than one health worker was responsible for the sick child clinic, the one who conducted sick child clinics most often or the most senior/experienced health worker was identified and requested to participate in the assessment. Only one health worker observation was conducted at each facility.

All children under age 5 presenting to the health facility during the survey period whose caretakers described them as having fever/malaria, cough/difficulty breathing/pneumonia, or diarrhea/vomiting were included in the sample. Mothers (caretakers) whose children were consulted were then interviewed post consultation. The head of the facility was also interviewed and a checklist for the equipment, supplies and other services offered by the facility completed. A community representative was interviewed about the status of existing linkages between the health facility and the community.

Data from the 76 district facilities and 25 ProFam facilities was cleaned then entered and analyzed using EPI Info 2000.

EIP BASELINE RESULTS

EIP KPC Baseline January 2006

	EIP Zone	1. Bafut	2. Fundong	3. Mbengwi	4. Ndop	5. Akonolinga	6. Awaé	7. Esse	8. Batouri	9. Bertoua	10. Doume	11. Nguemendouka
1. % of children age 0-23 months who are under-weight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	15.9%	6.5%	11.2%	8.5%	15.8%	10.5%	13.7%	12.6%	20.0%	23.2%	15.8%	43.8%
2. % of children born at least 24 months after their immediate surviving elder	52.3%	35.1%	74.1%	62.8%	66.7%	70.5%	66.7%	62.8.1%	38.1%	37.0%	55.8%	20.4%
3. Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	58.9%	61.8%	60.2%	62.8%	61.1%	54.7%	45.3%	52.6%	60.3%	52.6%	65.3%	68.8%

	EIP Zone	1. Bafut	2. Fundong	3. Mbengwi	4. Ndop	5. Akonoling a	6. Awaé	7. Esse	8. Batouri	9. Bertoua	10. Doume	11. Nguemem douka
4. Percentage of children age 0–23 months whose births were attended by skilled health personnel	59.9%	88.8%	79.6%	88.3%	90.5%	56.8%	50.5%	51.6%	23.2%	50.5%	28.4%	28.1%
5. % of children age 0-5 months who were exclusively breast-feeding during the last 24 hours.	50.8%	56.5%	52%	51.1%	48.4%	29.5%	34.7%	46.3%	23.2%	69.5%	67.4%	76.0%
6. % of children age 6-9 months who received breast-milk and complementary foods during the last 24 hours.	92%	95.1 %	93.9.0%	94.7%	94.7%	90.5%	90.5%	91.6%	90.5%	96.8%	90.5%	87.4
7. Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	70.5%	81.2%	90.2%%	89.0%%	76.5%	30.4%	62.5%	61.4%	37.5%	57.4%	56.7%	86.4%
8. Percentage of children age 12–23 months who have received measles vaccination before the first birthday	80.9%	89.3%	98.8%	94.5%	83.5%	43.5%	80.4%	69.6%	52.5%	76.1%	70.1%	95.3%
9. % of children age 0-23 months who slept under an insecticide-treated net the previous night.	11.8%	10.0%	3.1%	12.8%	2.1%	17.9%	23.2%	22.1%	7.4%	11.6%	9.5%	12.5%

	EIP Zone	1. Bafut	2. Fundong	3. Mbengwi	4. Ndop	5. Akonoling a	6. Awaë	7. Esse	8. Batouri	9. Bertoua	10. Doume	11. Nguemem douka
10. % of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment.	65.9%	65.3%	60.2%	64.9%	56.8%	70.5%	64.2%	76.8%	64.2%	83.2%	53.7%	65.6%
11. % of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	9.2%	15.0%	4.9%	13.5%	8.2%	5.9%	9.0%	7.6%	5.9%	13.0%	7.7%	9.3%
12. Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	64.6%	74.7%	70.4%	68.1%	73.7%	62.1%	73.7%	57.9%	36.8%	64.2%	61.1%	60.4%
13. % of mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.	7.7%	7.6%	5.1%	7.4%	24.2%	1.1%	14.7%	1.1%	1.1%	4.2%	15.8%	2.1%

	EIP Zone	1. Bafut	2. Fundong	3. Mbengwi	4. Ndop	5. Akonoling a	6. Awaë	7. Esse	8. Batouri	9. Bertoua	10. Doume	11. Nguemem douka
14. % of children with signs of severe childhood illness who were seen by a qualified public or private provider in the past two weeks.	37.4%	54.9%	45.7%	53.8%	52.1%	25.3%	12.4%	22.8%	31.7%	29.0%	60.3%	25.3%
15. % of pregnant women who slept under an insecticide-treated net the previous night	15.7%	-	8.2%	16.0%	8.4%	35.8%	18.9%	20.0%	6.3%	20.0%	11.6%	12.5%
16. % of women who completed at least one dose of Intermittent Presumptive Treatment (IPT) during their current or last pregnancy.	18.5%	25.3%	32.7%	29.8%	61.1%	2.1%	7.4%	2.1%	8.4%	10.5%	11.6%	7.3%
17. % of children age 0-59 months who received a full-course of recommended anti-malarial (according to the MOH's recently approved home-management protocols) within the 24 hours of the onset of fever.	11.7%	8.5%	0.0%	7.4%	2.7%	12.2%	22.2%	14.3%	14.7%	2.3%	34.0%	4.9%
18. % of children age 6-9 months who consumed food rich in protein in the 24 hours preceding the survey	65.4%	74.7%	66.3%	54.3%	78.9%	62.1%	75.8%	73.7%	47.7%	55.8%	56.8%	66.3%

	EIP Zone	1. Bafut	2. Fundong	3. Mbengwi	4. Ndop	5. Akonoling a	6. Awae	7. Esse	8. Batouri	9. Bertoua	10. Doume	11. Nguemendouka
19. % of children age 6-9 months who consumed food rich in oil in the 24 hours preceding the survey	33.8%	50.0%	35.7%	61.7%	35.8%	34.7%	32.6%	20.0%	15.8%	13.7%	32.6%	27.1%
20. % of children age 6-59 months who received a vitamin A supplement in the prior 6 months	80.9%	92.9%	78.6%	70.2%	90.5%	85.3%	73.7%	73.3%	66.3%	80.0%	84.2%	85.4%
21. % of mothers giving birth in the last 12 months who received two vitamin A supplements within 8 weeks post partum.	21.6%	-	22.4%	26.6%	37.9%	8.4%	17.9%	20.0%	35.8%	20.0%	16.8%	9.4%
22. % of pregnant women taking iron/folate supplements daily for at least 6 months during their last pregnancy.	27.2%	32.4%	29.6%	26.6%	32.6%	27.4%	43.2%	41.1%	16.8%	23.2%	14.7%	7.4%
23. % of children 6-59 months of age eating vitamin A rich foods of animal source (\geq 4days a week) and or of animal/vegetable (source \geq 6 days a week)	41.3%	50.6%	27.6%	58.5%	66.3%	34.7%	22.1%	27.4%	44.2%	45.3%	45.3%	27.1%

EIP IHFA Baseline January 2006

			EIP Zone		North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent	Percent	Percent
SREENING								
1	Proportion of children who were assessed for all danger signs	6.0%	0.5%	9.8%	17.5%	1.0%		
2	Proportion of children who were assessed for all main symptoms	9.9%	2.2%	15.2%	26.3%	1.0%		
CLINICAL EXAMINATION								
3	Proportion of assessment tasks completed for sick children with a history of diarrhea	38.7%	33.3%	41.0%	49.7%	49.2%		
4	Proportion of assessment tasks completed for sick children with a history of ARI	51.9%	48.8%	56.0%	56.6%	56.6%		
5	Proportion of assessment tasks completed for sick children with a history of fever	37.5%	31.6%	48.7%	36.8%	49.4%		
6	Proportion of children who had nutritional status assessed	8.7%	0.5%	12.0%	29.8%	7.6%		

		EIP Zone	North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent
7	Proportion of children whose weight was plotted on a growth chart	25.3%	23.0%	20.7%	40.4%	3.8%
Supporting information						
	Proportion of children who were weighed the day of the survey	85.8%	88.5%	85.9%	77.2%	93.3%
8	Proportion of children who had vaccination card checked at sick child visit	53.0%	47.5%	65.2%	50.9%	41.9%
9	Proportion of children who needed an immunization who received it on the day of the visit or were referred for vaccination	48.1%	44.4%	14.3%	72.7%	71.4%
Supporting information						
	Proportion of mothers who had their vaccination card checked at the time of the sick child's visit	6.4%	6.5%	3.5%	10.7%	1.9%
	Proportion of mothers needing a vaccination who received it the day of the visit or were referred to the next vaccination clinic	12.5%	25.0%	0.0%	0.0%	0.0%

EIP Zone			North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent
TREATMENT						
10	Proportion of children who received an appropriate medication for the diagnosis made by the health worker	57.6%	66.1%	47.8%	43.9%	34.3%
11	Proportion of children with simple diarrhea who received ORS/RHF	38.3%	32.0%	61.5%	58.3%	64.3%
12	Proportion of pneumonia cases who received an appropriate antibiotic	20.7%	17.7%	28.6%	36.4%	11.5%
13	Proportion of malaria cases who received an appropriate antimalarial	65.4%	68.4%	65.6%	52.6%	35.3%
Supporting information						
	Proportion of children with simple diarrhea who received an antibiotic or an antidiarrheal	78.3%	92.0%	66.7%	70.6%	71.4%
	Proportion of children with simple URTI who received an antibiotic	70.8%	82.1%	28.6%	33.3%	60.0%
INTERPERSONAL COMMUNICATION						

		EIP Zone	North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent
18	Proportion of treatment counseling tasks completed for sick children	42.7%	34.9%	51.4%	53.5%	35.1%
19	Proportion of children whose caretakers were counseled on the importance of giving fluids at home	26.2%	19.1%	30.4%	42.1%	2.9%
20	Proportion of children whose caretakers were counseled on the importance of giving food or breastfeeding at home	33.7%	27.3%	38.0%	43.9%	6.7%
21	Proportion of children whose caretakers were given advice on when to return	22.9%	18.6%	27.2%	29.8%	4.8%
Supporting information						
	Proportion of children whose caretakers were told how to administer oral medications	83.7%	81.5%	87.1%	84.9%	71.0%
TRAINING						
22	Proportion of health workers who saw sick children and who had received training in the management of child illness in the last 12 months	60.5%	51.7%	69.2%	61.9%	36.0%

		EIP Zone	North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent
23	Proportion of health workers with correct knowledge of when to refer a sick child	56.6%	65.5%	50.0%	52.4%	52.0%

**Supporting
information**

	Proportional distribution of training received in the last 12 months, by type of training	IMCI	50.0%	0.0%	61.1%	92.3%	0.0%
		OTHER	50.0%	100.0%	27.8%	7.7%	100.0%
	Proportion of last training sessions that involved clinical practice		78.3%	60.0%	100.0%	69.2%	53.8%
	Proportion of health workers with correct knowledge of the EPI calendar		78.9%	82.8%	88.5%	61.9%	96.0%
	Proportion of health workers who were unable to refer sick children in the past		61.8%	51.7%	57.7%	81.0%	83.3%

		EIP Zone	North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent
	Distribution of reasons for being unable to refer sick children due to the causes below					
	Next level facility too far	4.3%	0.0%	0.0%	11.0%	0.0%
	No transport available	36.2%	26.7%	36.2%	58.8%	10.0%
	Parent didn't have enough money	74.5%	66.7%	86.7%	70.6%	95.0%
	Caretaker refused to go	42.6%	26.7%	64.7%	42.6%	70.0%
	No fuel available	2.1%	0.0%	0.0%	5.9%	0.0%
SUPERVISION						
24	Proportion of health workers who had received at least one supervisory visit in the last 6 or 12 months	82.9%	86.2%	84.6%	76.2%	84.0%
Supporting information						
	Average number of supervisory visits per year per health facility	7.7	8.2	6.8	3.3	11.7
	Proportion of health workers who had received feedback from supervisor	84.1%	100.0%	77.3%	68.8%	61.9%
MANAGEMENT OF SICK CHILD AT HOME						

		EIP Zone	North West	East	Center	PROFAM (Within Yaounde)
No.	Indicator	Percent	Percent	Percent	Percent	Percent
25	Proportion of children receiving oral medications whose caretakers knew correctly how to administer the treatment at home	74.5%	82.3%	64.8%	62.5%	67.6%
26	Proportion of caretakers who knew how to correctly manage the child at home	57.8%	57.8%	73.8%	57.8%	29.5%
27	Proportion of caretakers who knew at least two signs of when to return if the child became worse at home	61.4%	66.7%	57.6%	50.9%	41.0%
AVAILABILITY OF DRUGS AT THE HEALTH FACILITY						
28.a	Proportion of health facilities that had experienced at least one stock-out of ORS in the previous month	7.9%	6.9%	7.7%	9.5%	12.0%
28.b	Proportion of health facilities that had experienced at least one stock-out of essential drugs in the previous month	7.9%	3.4%	3.8%	14.3%	8.0%
29	Proportion of health facilities with up to-date immunization and patient registers	67.1%	86.2%	61.5%	47.6%	80.0%

C) Qualitative Data Collection

- FOCUS GROUP DISCUSSIONS

Two FGDs were organized in each health district, giving a total of 22 for the 11 health districts. One was for CBOs and the other was for caregivers (Mothers and Fathers). Each FGD comprised about 10 to 12 participants. During the FGD notes were taken and tape recording was done after the prior authorization of the participants. The tapes were then transcribed and a thematic analysis done. Topic Guides are attached in Annex 4.

- IN DEPTH INTERVIEWS

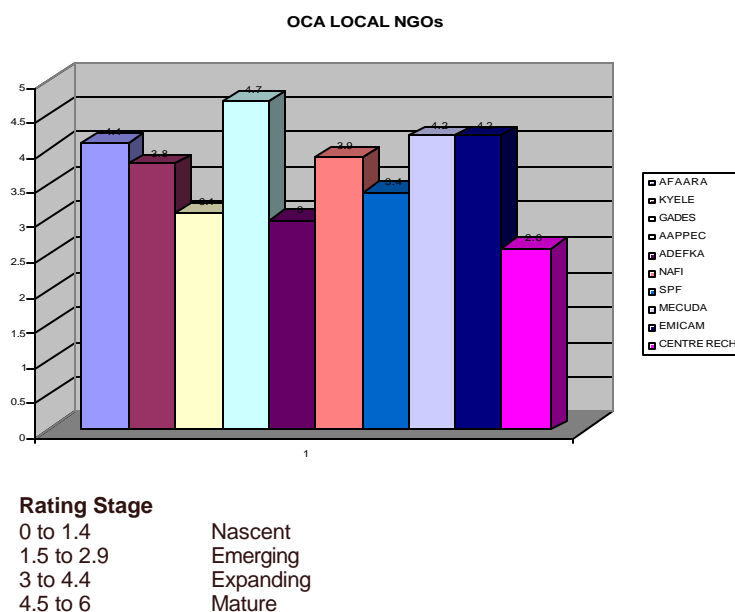
In depth discussions were held with each of the 11 DMOs.

- CHILDREN CONSULTATION WORKSHOPS

Three children consultation workshops were held, one in every province. These brought together 10 to 12 school children aged 5 to 10 years to talk about their health and health related issues.

- ORGANIZATIONAL CAPACITY ASSESSMENT

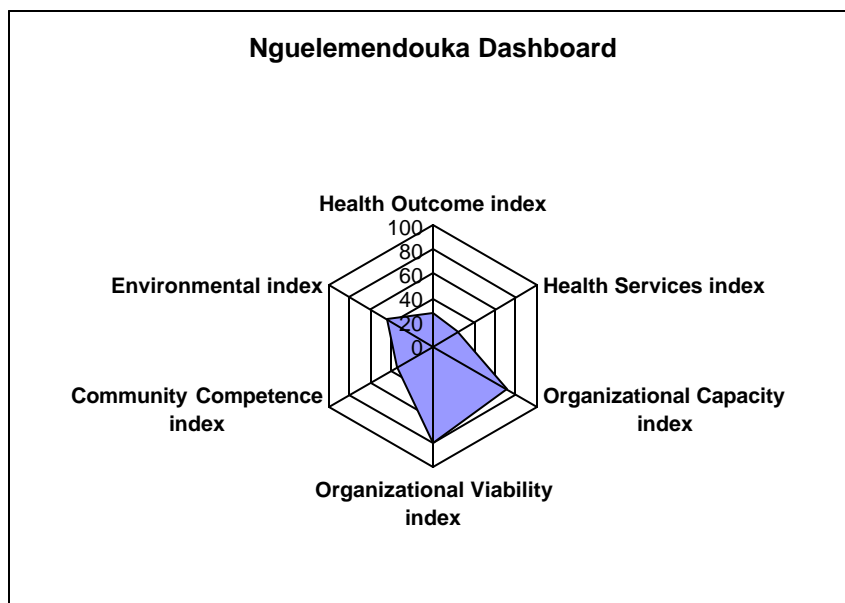
The OCA was conducted for 10 local partner NGOs (AFAARA, ADEFKA, KYELE, MECUDA, AAPPEC, GADES, EMICAM, Centre des Recherche, SPF and NAFI). The performance of the partners were assessed on the six main domains of governance, management practices, human resources, financial resources, service delivery, external relations and sustainability and each was scored on a performance scale 1(weak) - 6(strong). These scores were then classified into one of four categories (Nascent, Emerging, Expanding and Mature) within each domain, and aggregated and reclassified into a similar category for the entire organization. All local NGOs assessed ranged from Emerging to Mature. Only one, AAPPEC, scored maturity status on the corporate level.



- CHILD SURVIVAL ASSESMENT FRAMEWORK (CSSA)

The Child Survival Sustainability Assessment Framework (CSSA) was used to draw a baseline situation of the major determinants of sustainability for the local system using available data from the baseline survey and other sources including district routine data and DHS 2004. Six main components (determinants of sustainability) were identified, defined and given a quantitative measure in this evaluation: Health Outcomes, Health Services, Organizational Capacity, Organizational Viability, Community Competence, and External Environment. A new tool known as the Malaria Community Competence tool was used to measure the determinant of Community Competence (see below). A Dashboard was developed for each of the 11 districts. Generally the sustainability snapshot ranged from poor to intermediate. The CSSA process contributed to the EIP program development by:

- Profiling the emerging role of the “Health Coordination Committee” usually convened by the DMO and that brings together local stakeholders, as a champion for sustaining health programs, and a forum that needs to be strengthened
- Demonstrating the need to address Quality and Access issues within the health system as these are central to sustainability
- Identifying local NGOs need for knowledge transfer skills to CBOs/Communities on key family behaviors as well as skills in promoting facility to community collaboration
- Illustrating the dire need for resource mobilization skills by NGOs and CBOs to maintain Viability
- Revealing the need for community mobilization approaches that strengthen community ownership and participation in development programs
- Identifying opportunities to link with other programs/partners working in the areas of provision of Clean Water, Literacy, mitigating Political Interference, and influencing policy on hire of civil servants (health personnel) etc as these are important issues to assure sustainability.



- **SELF ASSESSMENT BY THE COMMUNITY ON MALARIA COMPETENCE**

The Forum V meeting in Yaounde Cameroon (November 2005) presented initial findings from Kenya of use of the Community Self Assessment Framework for Malaria Competence tool. This tool, developed by the Constellation for AIDS Competence, headed by Jean-Louise Lamboray, self assesses the current status and the desired target for 14 competency areas (related to malaria) within a community. These competency areas that are Knowledge and Practice based are:

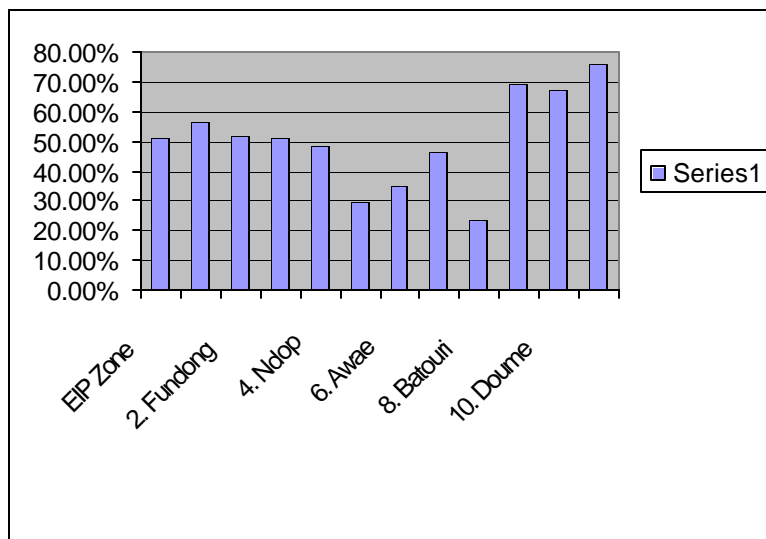
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|--------------------------------|------------------------------------|
| 1. Malaria is a Fact of life | 8. Prevention IPT |
| 2. Acknowledgement | 9. Gender Driven Response |
| 3. Inclusion of the Vulnerable | 10. Learning and Transfer |
| 4. Access to treatment | 11. Measuring Change |
| 5. Severe Malaria | 12. Adapting our Response |
| 6. Prevention ITN | 13. Ways of Deploying our Strength |
| 7. Prevention IRS | 14. Mobilizing Resources |

The tool is used as a strategizing and planning tool in that it compares “current” and “target” levels of achievement, prioritizes which targets to aim for first and then strategizes how to reach to that level of competence through the elaboration of an action plan. Scores for each parameter range from Level 1(nascent) to Level 5 (fully mature) Built into this tool is a presentation diagram called “river and stairs” that allows multiple communities to recognize those “competency areas” that they still need to work on and from whom (amongst their peers) they have an opportunity to learn from.

DISCUSSIONS OF PROGRAMMING PRIORITIES IDENTIFIED AND IMPLICATIONS

- **Implementation strategy:** The LQAS allowed the EIP team to determine the community health situation at the Health Area level, District level and EIP (National) level. This is helping the EIP focus community interventions appropriately. Some Districts and Health Areas will be targeted for a greater intensity of a particular Intervention(s) based on this evidence and a prioritization within the community. This has implications on the level and type of support that each local NGO will expect to receive from the EIP. Also with 1543 communities within the project area, the need to have more than 3 local NGOs as implementing partners was identified. The EIP proposes to work with 11 local NGOs each focusing on one district.
- **Breastfeeding:** Only 50.8% of the mothers exclusively breastfed their babies. During the FGDs mothers gave the following reasons for not exclusively breastfeeding babies: breast milk alone is not sufficient for the child, some mothers are working, the baby refuses to breast feed, some of the babies are orphans, some of the mothers are ill or that the breast milk is otherwise spoiled as in where a mother has HIV or where a nursing mother consumes sweet foods, or when she has had sex with the husband. Another reason reported was exclusive breastfeeding was delaying weaning and this was perceived to have negative consequences: “If a child stays for long without getting used to the family dish it will never want to eat it again.” Exclusive breastfeeding is erroneously thought to be one of the major causes of malnutrition. The implication of these results is that greater emphasis has to be placed to break the cultural myths surrounding breastfeeding in the course of the EIP.

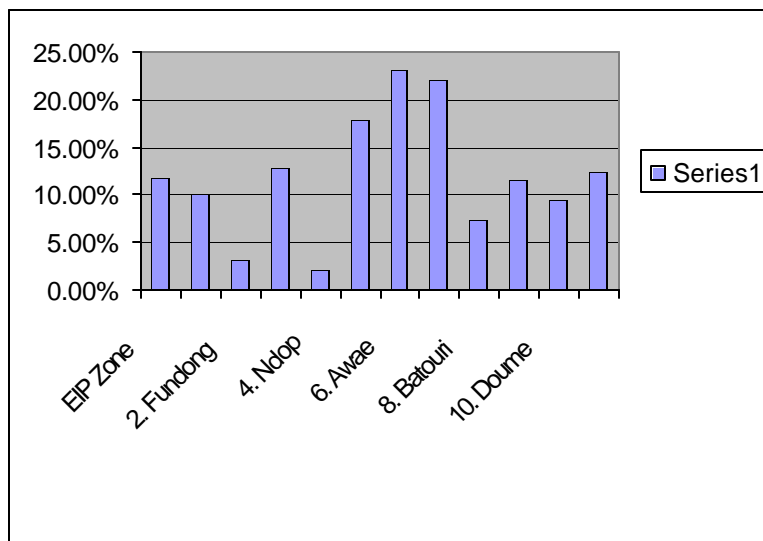
Exclusive Breast Feeding Rate across the 11 Districts



- **ITNs:** ITN use by both pregnant women and children 0-23 months was quite low (11.8% and 15.7% respectively). Caregivers and the CBOs gave the following

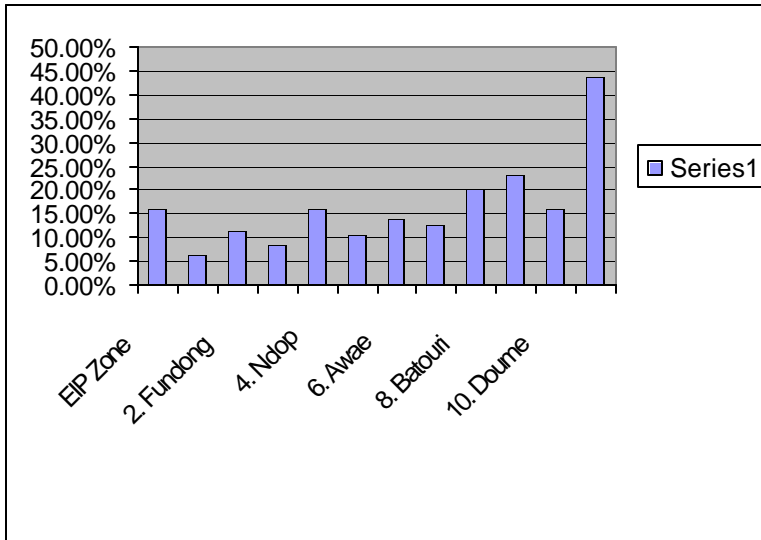
reasons for the low rate during the FGDs: ITNs are costly (4000 francs or 8 dollars is expensive and people want it for free), ITNs produce heat, the insecticide found in the nets is poisonous to human beings, people just don't know about ITNs (lack of knowledge), some people have claustrophobia, a net looks like a coffin and people want ITNs but cannot find them (Non availability). The two issues that stand out are those related to Access (cost and availability) and those that relate to acceptability of ITN use. Mothers were generally aware of the importance of ITNs in the prevention of malaria. The implication is that the EIP will focus on increasing ITN availability through social marketing (ACMS) and/or through free distribution (MOH and Plan Cameroon) and work to raise the awareness of the population on ITN acceptability and use.

Level of ITN Coverage across the 11 Districts



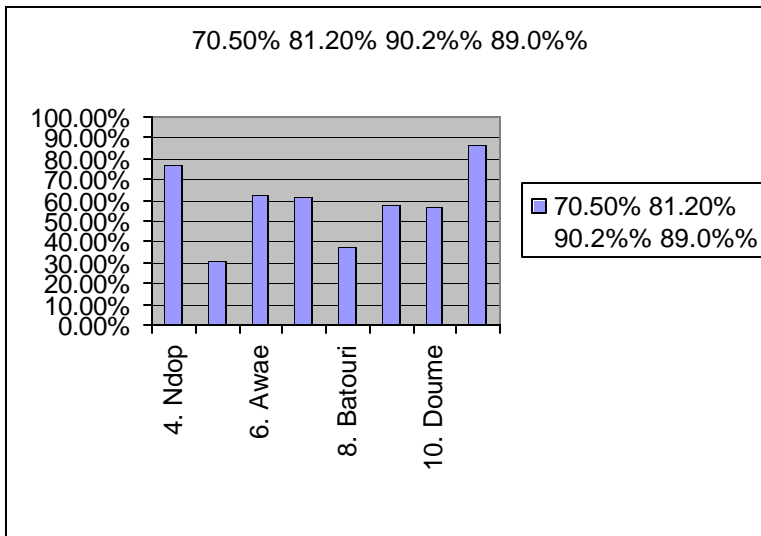
- PD/Hearth: An average of 15.9% of children age 0-23 months are under-weight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population) in the 11 health districts. This is slightly better than the national average of about 18.0% (DHS III). However at provincial level, disparities exist and in Nguelemendouka health district with level of underweight children of 43.8%. Both mothers and DMOs expressed a need to have community rehabilitation sites (Hearth) to address malnutrition.

Level of Underweight coverage across the 11 Districts



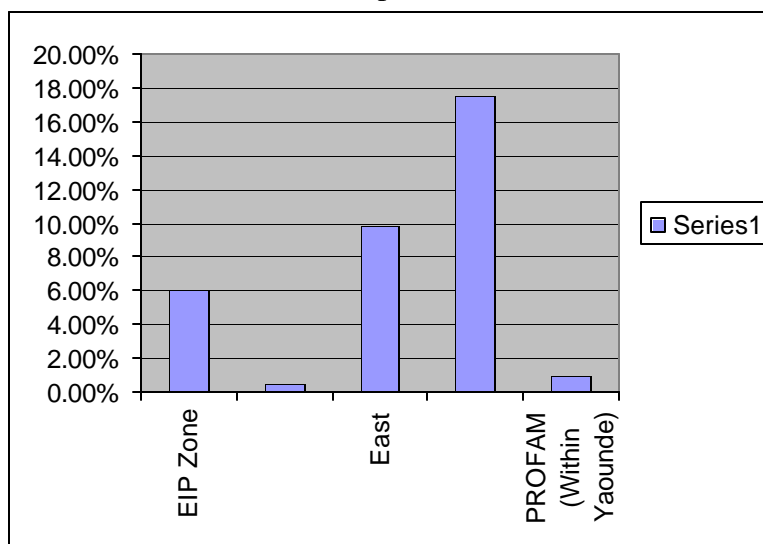
- Immunization:** Whereas the general average for fully immunized children 0-23 months is 70.5% (from vaccination cards), some health districts are faring poorly including Akonolinga at 30.4% and Batouri at 37.5%. Mothers raised the issues of cost associated with routine vaccination, and geographical inaccessibility to the vaccination centers as some of the major deterrents to vaccination. Mothers expressed need for more outreach posts that provide the minimum health package including immunization service. The EIP project had not initially included immunization in the list of specific interventions. Given this scenario a decision was made to include it.

Level of Immunization Coverage across the 11 Districts



- DMO Interviews:** The DMOs expressed difficulties with transport being the major barrier to performing supervision and other routine activities smoothly. Therefore, there is a need for greater investment by stakeholders in the constructing of the annual district health workplan.

- **IMCI Training:** The IHFA revealed that only 14.2% of the frontline staff that took care of sick children in all the Health Districts had been trained on IMCI. This explains why only 6% and 9.9% of sick children were assessed for all danger signs and all main symptoms respectively. This lack of training also explains the observed extensive use of antibiotics in the treatment of simple diarrhea (78.3%) and simple upper respiratory tract infections like colds (70.8%). Another important finding was the fact that health personnel from the Center Province, which benefited from the most recent training event, exhibited greater IMCI compliance (screening of sick children [17.5% vs. 9.8%] and interpersonal communication [43.9% vs. 38%]) than colleagues from the East Province who had more personnel trained in IMCI through earlier events. Without adequate supervision there seems to be a rapid loss of the skill set acquired during the IMCI training. There is need for IMCI training and supervision of frontline health staff. Results of the in depth interviews with DMOs provided concurrence for this.



Level of Assessment of Danger signs in the 3 provinces and ProFam Clinics

b. Potential constraints to achieving program objectives based upon country context, and project strategies for overcoming these constraints

The beneficiary population is large and composed of several communities. The Project will have to work with existing local NGOs to effectively reach the entire beneficiary population via existing women's groups or CBOs. The project has already identified local NGOs within each district, which it will appoint as sub grantees for local implementation.

MOH Outreach will be an important facet if the project is to succeed. The district Health System managers expressed transportation difficulties as the major cause for inability to conduct field supervision and other routine activities. An annual workplan is drawn in December of every year at the district level and it maps activities for the coming year and the resources that will be required. The EIP will work with the district MOH teams

and other collaborating partners to ensure that expertise, experiences and resources are shared at this level and through these workplans so as to prevent duplication of activities in some areas and a complete absence of activities in other areas. With this forward planning it will be possible to schedule activities appropriately and to share existing transport to particular areas during programmed activity that will allow the full implementation of the workplan.

For the Malaria Intervention, the provision of ITNs and Home Treatment Kits will have to be provided by the GOC through the Global Fund Grant if the EIP objectives are to be realized.

When the project proposal was being developed, it was hoped that the National Malaria Program would have already rolled out home kits for malaria treatment into the Market by 2006. The urgent and timely management of fever at home will continue to be hampered if the home kits are not available. The MOH is currently negotiating the 5th round of the Global Funding Mechanism to finance the malaria home kit. Another issue with the ACT combination of Artesunate and Amodiaquine, which constitutes the first line treatment of Malaria and the Home Kit, is the number of tablets that have to be consumed. Any complexity will minimize compliance within the households. Sanofi-Aventis Pharmaceuticals are now at an advanced stage of releasing a brand into the market that has successfully combined the two molecules to allow for a smaller number of tablets and a more regular administration routine that will maintain compliance.

Cost will continue to be a deterrent for ITN ownership in the Project Area. The project intends to sensitize mothers and pregnant women to acquire and use ITNs. Even though ACMS will be doing social marketing for ITNs, it is expected that the MOH and other partners including Plan Cameroon will continue to provide free bed nets to under-five children, pregnant mothers and WRA. Where this continues to be done there is the opportunity within the coordination function of these programs within the life of the EIP to negotiate on criteria to be followed when distributing free ITNs so that the exercise is not marred with chaos or drive a wrong message to the community.

c. Up-to-date coverage estimates in the service area

Malaria

EIP KPC (2006) revealed that less than 12% of children age 0-23 months slept under an ITN the previous night with the lowest rates found in Ndop (2.1%) and Fundong (3.1%). The highest coverage was in Awae (23.2%). 15.7% of pregnant women in the project area spent the previous night under an ITN. The highest coverage was in Akonolinga (35.8%) and the lowest in Batouri (6.3%).

Also, 18.5% of women completed at least one dose of IPT during their current or last pregnancy. This was highest in the North West Province Health Districts (Ndop, 61.1%; Fundong, 32.7%; Mbengwi, 29.8% and Bafut, 25.3%) while the lowest rates were observed in the Centre Province (Awae, 7.4%; Akonolinga, 2.1% and Esse, 2.1%). These results are in line with DHS III 2004 that reported IPT completion rates of 2.8% in North West province, 1% in the East province and 0.5% in the Centre province.

11.7% of children age 0-59 months received a full course of recommended anti-malarial within the 24 hours of onset of fever; this is highest in the Centre (16 %), intermediate in the East (14.9%) and lowest in the North West (4.8%). This allies well with DHS III 2004, which revealed 10.6% in the Centre province, 8.4% in the East and 5.5% in North West province. There is however notable variation on malaria prevention and management within these areas that may be as result of other specific interventions.

Within the context of the routine activities of the National Malaria Control Program, the North West provincial Malaria Control Unit had undertaken a provincial sensitization campaign within all ANC units in the health facilities on the new IPT policy using SP. This was not the case with the other provinces. This can probably partially explain the edge the North West province has over the other provinces as far as IPT use is concerned.

With regards to ITN, the Akonolinga Health District has been running a Plan France National Office funded ITN project for the past one year and this has certainly impacted positively on the indicator of ITN use in this region.

The EIP IHFA (2006) reported that only in 37.5% of sick children evaluated with fever had assessment tasks for sick children with a history of fever completed. Also 65.4% of malaria cases seen in health facilities received appropriate anti-malarial (according to the transitory policy for malaria treatment). Accessibility to the newly recommended ACT remains a major obstacle to malaria management.

Malnutrition

Nutritional status of Cameroonian children varies across the country. The DHS III 2004 gave an average underweight prevalence of 17.3% for boys and 18.8% for girls as shown below.

Nutritional Status of children 0-59 months (<-2 SD mean weight for age) DHS III 2004	
Age group	Value
< 6 months	1.2%
6-9 months	12.3%
10-11 months	23.6%
12-23 months	28.4%
24-35 months	20.1%
36-49 months	15.8%
48-59 months	16.5%
Boys	17.3%
Girls	18.8%
East	17.7%
Center	7.9%
North West	13.6%

Although food is available and the diet of Cameroonians is more diverse than in many countries, many Cameroonian children do not eat an adequate quantity or quality of food. In the East Province most children eat only twice per day. Young children throughout

Cameroon eat animal sources of vitamin A, significantly more bio-available than plant sources, once per week on average with eggs accounting for the majority of consumption. Eggs are available, but often sold as a source of income for the family. Red Palm Oil, although widely available and consumed by children, is often completely bleached before serving, thereby destroying the vitamin A.^{xvi}

The EIP KPC 2006 found that **80.9 %** of children aged 6 to 59 months received Vitamin A supplements in the last 6 months. Persistent micronutrient deficiency and malnutrition confirms the need to adopt innovative approaches like PD/Hearth. With funding from the Japan National Plan office, Plan Cameroon began the only PD/Hearth program in Cameroon, where some children participating in the first round gained up to 1200 grams.^{xvii} Since the final evaluation of the project, Plan Cameroon obtained a three-year grant from the Plan Netherlands National Office to consolidate the PD/Hearth approach in existing Plan project areas.

Low access to IFA and low compliance in taking IFA supplements by pregnant women affects both the mother's and child's health and is an important contributing factor to the high anemia prevalence of 51% among pregnant women (DHS III) and low birthweight (12%). Anemia prevalence is 43,6%(DHS III) among lactating mothers. EPI KPC 2006 showed that only **21.6 %** of postpartum mothers received 2 mega doses of Vitamin A within 6 weeks.

While it is known that child malnutrition is the underlying cause in nearly 60% of child deaths in Cameroon, and is usually present to some degree in the greater proportion in sick children, EIP IHFA 2006 revealed that only 8.7% of sick children had their nutrition status fully assessed. Despite 85.8% of sick children having their weights taken when they were ill only 25.3% of these children had weight plotted on the growth chart. Also only 33.7% of the caretakers were counseled about continuing feeding and breastfeeding for the sick child at home.

Diarrhea

In Cameroon, 16% of children less than 5 years of age had one or more episodes of diarrhea in the preceding 2 weeks.^{xviii} On a national level, ORS are used in only 23%^{xix} of cases. Only 3 out of 5 Cameroonians have access to clean water, with only 39% enjoying access in rural areas.^{xx} The Société Nationale des Eaux du Cameroun's (SNEC) capacity to produce and provide clean water is very limited. The most recent official report^{xxi} showed that only 20% of the population is linked to the national water system. Another 20% get water from public (SNEC) water faucets and 60% get their water from wells and surface streams. These numbers hide certain regional disparities, such as constraints linked to the provision of clean water in urban areas, pockets of poverty in large cities and rural areas, and seasonal changes that make water scarce in certain areas and perpetuate outbreaks of cholera, dysentery and other diarrheal disease during the dry season. Low-income households often have the least access to clean water.

Many low-income families lack information on appropriate hygiene practices, such as hand washing. EIP KPC 2006 revealed 7.7% of caretakers washed their hands before preparing food for a child, before feeding a child, after changing the diaper of a child who had defecated and after the caretaker returns from defecating.

Point of water treatment using chlorination kits is currently not yet practiced in the community. ACMS has just received approval from the Ministry of Trade to zero-rate tax

on these kits and is in the process of launching and beginning active social marketing of “Sur’Eau/Waterguard”.

EIP IHFA 2006 showed that only 38.7% of sick children with a history of diarrhea had assessment tasks for diarrhea completed. Those with simple diarrhea who received ORS/RHF was only 38.3% however it was higher in the East and Center (61.5% and 58.3% respectively) where IMCI training had been provided to health workers. Proportion of children with simple diarrhea who received an antibiotic or an antidiarrheal was 78.3% (It was 92% in the North West Province where Health Workers are yet to receive IMCI training).

Zinc use in diarrhea management has not begun at all but the MOH is very supportive of the pilot assessment that will be done by the EIP through HKI in 3 districts. The MOH is also hazy about adopting the Low osmolarity ORS because of what it cites as a weak evidence base regarding its active use in Cholera epidemics. ACMS still markets the normal ORS through its network of 12,000 vendors.

Pneumonia

EIP KPC 2006 showed that **75.2%** of children 0-23 months in the Northwest province experienced rapid or difficult breathing, while **66.7%** of children experienced these symptoms in the Center and **42.4%** in the East provinces. Only half or 51.9% of sick children presenting with a history of ARI had all ARI assessment tasks completed according to the EIP IHFA 2006. Also proportion of pneumonia cases that received an appropriate antibiotic was 20.7% and proportion of children with simple URTI who received an antibiotic was 70.8%

Immunization

Whereas the general average for fully immunized children is 70.5% (EIP KPC), some health districts are faring poorly including Akonolinga at 30.4% and Batouri at 37.5%. Mothers raised the issues of cost associated with routine vaccination, and geographical inaccessibility to the vaccination centers as some of the major deterrents to vaccination. Mothers expressed need for more outreach posts that provide the minimum health package including the immunization service.

According to the EIP IHFA 48.1% of children and 12.5% of mothers, needing an immunization, received it on the day of the visit or were referred to the next vaccination clinic.

MOH adopts an Open Vial policy that allows for any child or pregnant mother to get a vaccination when they present to the clinic. However stockouts of essential drugs/Vaccines were reported in 7.9% of the facilities. Also proportion of health facilities with up-to-date Immunization registers was 67.1%. Not enough information was present at every health facility to adequately respond to the vaccination needs of the catchment area. Coverage for 2TT for mother of children age 0-23 months was 58.9% (EIP KPC 2006). With the National Immunization Days set to conclude this year (2006) in Cameroon, the EIP DIP workshop proposed to include Immunization as one of the intervention areas.

2005 Annual Synthesis for EPI including DPT Drop-Out Rate. Source: WHO Cameroon/ EPI MOH Cameroon

DISTRICTS &PROVINCES	DPT. Hep. B 3	Polio 0	Polio 1	Polio 2	Polio 3	Measles	Yellow Fever	TT 1	TT 2	TT 3	TT 4	TT 5	TT 2+	VIT. A	Drop Out Rate DPT
Akonolinga	32%	14%	21%	24%	32%	15%	20%	20%	26%	4%	0%	0%	30%	2%	12.6%
Awae	76%	54%	71%	78%	76%	63%	63%	37%	29%	15%	10%	14%	67%	178%	3.71%
Esse	50%	30%	62%	51%	50%	46%	46%	4%	6%	5%	3%	2%	16%	39%	6.25%
CENTRE*	88%	77%	91%	88%	88%	76%	75%	51%	42%	17%	8%	5%	81%	104%	7.38%
Batouri	106%	56%	121%	107%	106%	108%	102%	61%	45%	22%	10%	11%	87%	73%	17.91%
Bertoua	99%	62%	86%	84%	89%	74%	72%	45%	32%	19%	10%	8%	70%	38%	9.69%
Doumé	84%	80%	86%	76%	89%	81%	81%	28%	14%	11%	18%	15%	58%	49%	8.17%
Nguelemendouka	100%	57%	85%	98%	100%	80%	80%	40%	41%	37%	24%	16%	118%	113%	-2.7%
EAST*	88%	47%	85%	84%	86%	73%	70%	36%	37%	16%	10%	8%	70%	65%	12.52%
Bafut	52%	54%	58%	54%	52%	45%	44%	14%	8%	1%	4%	1%	15%	34%	3.84%
Fundong	46%	38%	58%	53%	46%	35%	35%	13%	10%	7%	1%	1%	19%	61%	6.48%
Mbengwi	68%	66%	61%	61%	68%	73%	73%	19%	16%	10%	6%	8%	40%	133%	3.1%
Ndop	83%	74%	87%	83%	84%	77%	77%	22%	12%	8%	10%	#REF!	29%	76%	-1.1%
NORTH WEST*	65%	58%	67%	65%	65%	56%	58%	21%	17%	10%	5%	4%	36%	64%	.66%

Disease Surveillance Data, Quality of the Data, and completeness of reporting

Malaria is a notifiable disease in Cameroon. The Malaria Control Program maintains active surveillance of Malaria in all health districts. However the quality of data and completeness of reporting is wanting given an analysis of the 2005 report, which shows that there were no reported cases of malaria in Akonolinga, which is untrue. Another questionable finding on the surveillance report is that there were no reported deaths from Malaria in Ndop, Nguelemendouka and Esse Health Districts.

Health Districts	Target Population			Age Groups											
	Total Population	0-5 years	Pregnant Women	0-28 days		1-11 months		12-59 months		5-14 years		15 years plus		Total	
				C	D	C	D	C	D	C	D	C	D	C	D
Bafut	80,731	14,532	4,037	18	0	688	1	1,247	1	1,065	0	3,024	0	6,042	2
Fundong	190,410	34,274	9,521	27	0	408	2	1,109	0	891	8	2,285	0	4,720	10
Mbengwi	77,956	14,032	3,898	8	1	213	3	595	3	602	5	1,609	4	3,027	16
Ndop	206,362	37,145	10,318	99	0	1,566	0	2,547	0	1,350	0	2,506	0	8,068	0
Province	2,040,555	367,300	102,028	720	2	10,414	22	19,634	19	15,166	29	41,267	29	87,201	101

* Provincial surveillance figures for the whole province and not average of the EIP health districts

Malaria Surveillance data for 2005 (Source: National Malarial Control Program)

NORTH WEST			EAST			CENTER		
HEALTH Districts	Notified cases	Deaths	HEALTH Districts	Notified cases	Deaths	HEALTH Districts	Notified cases	Deaths
Bafut	6,042	2	Batouri	5,059	10	Akonolinga	0	0
Fundong	4,720	10	Bertoua	6,015	2	Awae	1,512	1
Mbengwi	3,027	16	Doume	1,511	1	Esse	217	0
Ndop	8,068	0	Nguelemendouka	2,566	0			

Malaria Surveillance Data for North West Province for 2005 (Source: National Malaria Control Program)

Malaria Surveillance Data for The East Province for 2005 (Source: National Malaria Control Program)

Health Districts	Target Population			Age Groups											
	Total Population	0-5 years	Pregnant Women	0-28 days		1-11 months		12-59 months		5-14 years		15 years +		Total	
				C	D	C	D	C	D	C	D	C	D	C	D
Batouri	125,390	22,570	6,270	0	0	1,352	5	1,744	3	1,125	2	3,032	0	7,253	10
Bertoua	146,456	26,362	7,323	0	0	1,099	0	1,862	0	1,074	0	2,338	0	6,373	0
Doume	56,355	10,144	2,818	14	0	424	0	352	8	330	0	324	0	1,444	8
Nguele mendou ka	38,128	6,863	1,906	32	0	177	0	265	0	252	0	449	0	1,175	0
Total	890,325	155,743	43,262	372	0	8,751	26	12,908	33	7,249	9	19,490	10	48,770	78

3. Program Description

OVERALL PROGRAM STRATEGY

The EIP has the following goals:

1. To accelerate the scale-up of IMCI/RBM in Cameroon through the concerted effort of organized communities and public, private and international institutions by
 - Fostering community-based IMCI/RBM through the active involvement of men, women and children in village health structures and health outreach activities of the 11 health districts;
 - Applying facility-based IMCI/RBM in 11 health districts and to 25 private-sector ProFam health clinics through ACMS. IMCI/RBM will also be provided to facility-based staff in the 55 Health Districts of the East, Center and Northwest provinces.
 - Organizing a national constituency of private, public and international organizations to influence policy making and action towards the scale-up and sustainability of IMCI/RBM across Cameroon.
2. To disseminate successful program interventions and integrate IMCI/RBM within Plan, PSI and HKI's development programming in Cameroon and the region.

The EIP seeks 3 main results: Improved Family behaviors and home care, Increased access to quality maternal and child health services and Improved capacity for public and private partners' systems and structures to sustain CS activities.

Community Level: To achieve the 1st result the EIP will implement community IMCI. EIP has adopted the Household and Community IMCI Implementation framework developed by CORE for its community-oriented strategy. This framework identifies 3 linked elements supported by a multi-sectoral platform. These elements are: Improving partnerships between the facilities and the communities they serve, Increasing appropriate and accessible health care and information from community-based providers, and Integrating promotion of key family practices for child health and nutrition.

EIP's community-oriented strategy brings together 3 key stakeholders of health at the community level. These stakeholders are the COSA members (a.k.a. community dialogue structure), the women's groups and the traditional healers.

The Community Dialogue Structure comprises two elected members from each community. These officials, also known as the COSA, sit in the management committee of the Integrated Health Center (IHC). Because IHCs serve an average of about 15 communities, there are as many as 30 COSA members in each IHC. The Health Worker in charge of the IHC serves as the technical advisor of the COSA Committee. The COSA has an elected President from within its membership. Four members of the COSA committee are appointed to manage the cost recovery operations of the IHC Pharmacy. This group is called the COGE. The COGE is answerable to the COSA committee. COSA meets monthly at the IHC and conducts joint planning for health activities. COSA speaks on

behalf of the community about quality of health services offered at the IHC. They pass important surveillance information to the IHC and also share back to the community information about new IHC services and upcoming health campaigns.

Each community in the project area has a women's group. This group comprises about 20 to 50 active women members and has elected office bearers-President, Secretary General and Treasurer. Women's groups are commonly called CBOs because they engage in some form of income generating projects for the welfare of their members. Many women's groups in the project area have had previous experience with growth monitoring activities and communal net retreatment as part of Plan supported health activities. Most of these women are mothers and many are not formally employed. They are enterprising and role models in their communities. They usually meet as a group monthly. Individually have several opportunities to meet and engage with their friends and neighbors at the household level during which time they can share health messages and model key family practices. The monthly group meetings catalyses communal activities like community growth monitoring.

Traditional Healers are usually the first port of call for sick children in many communities. The GOC recognizes the important role played by these practitioners and has established an office of Traditional Medicine in the Ministry of Health. However this sector is not well organized and does not have clear criteria for membership. There are no proficiency certificates to identify practitioners and no established hierarchical structure within the group. This lends to leadership conflicts at the sub national and national levels. On the community level however traditional healers who are patronized by sick children are well known. They provide services on demand and are fairly accessible. They also accept compensation in kind which makes it easier for a significant proportion of the community. The quality of these services and linkages with the formal health system is poor. Efforts to link Traditional healers with the IHC are still rudimentary.

The first element of the Household and community IMCI framework will be addressed through the COSA committee who provide the linkages between the community and the formal health system. This is a two way partnership between facilities and communities and is focused on information sharing and joint planning and increasing demand for services. The second element will be addressed through involvement of Traditional Healers in the referral of sick children with danger signs to the formal health system. The third element will be addressed by women's groups who through community growth monitoring sessions and home visits will engage caretakers of children in sustainable behavior change. The multisectoral platform at the community level includes water and sanitation programs, agriculture and credit programs, and schools. EIP will sustain health practices through institutionalizing key family practices in other sectors. These sectors provide natural mechanisms for communicating and promoting key behaviors. Each sector has a relevant link with health and will be utilized to ensure that messages get to different members of the community at various places and in different ways. This repetition will help to create a common knowledge and influence behavior. Examples include incorporating hand washing messages into water and sanitation programs and using schools to train students as youth community health promoters. Efforts will also involve aligning different sectors to address barriers to change for key health practices.

Examples include increasing water and sanitation programs to address preventable causes of diarrhea and mobilizing income generation efforts to break down the economic barrier to ITN purchase.

The EIP will involve multi-stakeholder strategic planning to realize malaria competent communities. The Community Self Assessment Tool for Malaria uses participatory planning in a village and then works with multiple government ministries and partners to address identified needs. This process encourages inter and intra community dialogue and fosters community participation and ownership of project activities.

The principle behind the use of this tool is for communities to self assess competency on key practices that mitigate against malaria. These competency areas include Problem Identification, Problem Analysis, Identifying the most Vulnerable, Access to Services, Understanding Severe Malaria, Preventing Malaria, Gender Driven Responses, Learning and Transfer, Measuring Change, Adapting Responses, Ways of Deploying Community Strength and Mobilizing Local Resources.

Communities rank their competence, on a scale of 1 to 5, on selected practices and prioritize the practices that they wish to improve. They set themselves a target within a defined period of time, and elaborate an action plan to improve the prevailing situation. A subsequent assessment after this period of time reveals whether they improved or not. Built to the reporting of these results is the “river and stairs diagram” which is a graphic excel spreadsheet. It allows each community to know what they can share and from whom they can learn. This visual also displays distribution of the performance levels of a community on a set of practice indicators. Maximum and minimum scores for each practice are shown for comparison in the form of banks of the river.

During the life of the EIP this tool will be adapted to assess community competencies for all the other EIP interventions and facilitate the stakeholder discussion and planning meetings at the IHC.

The local NGO in each district will be the facilitator of community activities. A key activity for the EIP before the commencement of community activities is the training of the local NGOs. These NGOs shall be trained in four areas: (1)Community and Social Mobilization including facilitating behavior change through the BEHAVE framework, (2)EIP Intervention areas including specific standards of practice (e.g. Home management of Malaria with Home Kits (ACT), Retreatment of nets, Child Feeding), (3)Communication skills and (4)Health Information management.

Two distinct packages of community level activities will be implemented.

The first package of activities will target a series of capacity building activities within the community and will gradually phase into all the 1543 communities over the life of the project. The NGO will employ a phased approach to engage individual communities in EIP activities based on two factors: Prevalence of coverage of key behaviors and Accessibility to health services. Communities with poor prevalence score in the LQAS assessments and those that are hard to reach in every Health Area will be enrolled first. In each of the 11 districts 40 communities will be engaged every year for an annual total of 440 for Year 2, 3 and 4. In Year 5 the final 223 communities will be enlisted into the project.

The second package will be implemented simultaneously in all the 1543 communities in the project area and will center on the biannual Health and Nutrition week.

The local NGO will follow a series of steps while involving beneficiary communities. Introductory meetings with the community leader/Paramount chief will be held to introduce EIP activities. Specific meetings with the COSA representatives and the women group leadership will follow. Traditional Healers in the community who are actively engaged with care of the sick child will then be identified. The NGO will then facilitate the Malaria Competence Action Planning with all the community stakeholders. This will provide a forum for teambuilding as well as a roadmap for the community. The NGO will also facilitate the stakeholder discussions and planning meetings at the IHC. COSA members will receive training in basic financial management and information skills while enlisted Traditional Healers will be trained on identification of sick child danger signs and effective counseling of caretakers for immediate referral. Women's group (CBO) will be trained on Drawing a community map, Updating behavior trends in the community map and reporting on vital events, Counseling caretakers on healthy practices, Organizing community growth monitoring sessions, Conducting hearth sessions and Mobilizing communities for planned Health Campaigns like the Health and Nutrition Action Week.

The following Table shows activities that shall be implemented by EIP partners at the community level

Actor	Women's Groups	Traditional Healers	COSA	NGO	IHC Staff
<u>Daily</u>	Conduct Home Visits; Counsel about select key behavior; Refer sick children and those needing immunizations to IHC; Call backs after GM session	Consultations for sick children; Refer children with danger signs to IHC	Support Women CBOs and Traditional Healers in day to day activities; Channel challenges faced in implementation	Train and Mentor COSA, Traditional Healers and Women CBOs in their day to day activities; Ensure program Quality	Case management; Immunizations; Ante Natal Care
<u>Monthly</u>	GM sessions; Share home visit experiences; Assemble behavior map	Participate monthly at the multistakeholder discussion / planning at the IHC	Participate monthly at the multistakeholder discussion/ planning at the IHC	Participate monthly at the multistakeholder discussion/ planning at the IHC	Participate monthly at the multistakeholder discussion/ planning at the IHC
<u>Biannually</u>	Joint Participation in the Health and Nutrition Action Week				

The CBO members will mark all supplementation activities on the child's immunization or growth monitoring card, and will provide record of the supplementation to their COSA

representative so that the information can be shared with the health facility at the next COSA meeting. EIP will create a 'new mother' booklet for the EIP that will be given out through health centers. The booklet will provide information on preventing malaria, diarrheal disease, pneumonia and nutritional deficiencies, as well as immunization information. The 'new mother' pamphlet will also point to products and services that can be of use to the new mother and child. Other promotional materials, such as calendars, posters, or radio spots, will present the products as part of an integrated package. Community health resource persons (CHRs) will play an active part in the rehabilitation of malnourished children through PD/Hearth that will help achieve the 2nd EIP result of increasing access to quality care at the community. The local NGOs and the women's CBOs and local health personnel will participate in Health and Nutrition Action Week. Health and Nutrition Action Week brings the health worker to the community to conduct a range of services including immunization, prenatal care, treatment for simple illnesses, counseling, health education and relationship building. This approach saves caretakers the cost of transport and the time needed to visit a health facility and is especially convenient for communities in hard to reach areas. The local NGOs will assist health personnel and the women's CBOs in organizing transport for the health worker/medical supplies, conducting community mobilization to get the community to avail of the service at a particular time of the day and arranging for closure of the health facility during this time. Working together with the CBOs, COSA and COGEs, the MOH can maximize this opportunity to reach the community on a regular basis. The women's CBOs will keep a community calendar so that the health worker and citizens in the village can best prepare for the outreach activity.

The EIP will support Health and Nutrition Action Week every six months in each health district as part of the district work plan. Through this effort about 30 communities will be reached daily giving a total of 150 communities over 5 working days in every health district. Fifteen medical teams in every district, each comprising 2-3 health professionals and some volunteers, will reach 2 communities every day. Major activities will be Preventive Services (Immunizations, ITN Retreatments, and Vitamin A supplementation), Case Management Services (Free consultations, Dispensed drugs at cost recovery) and Promotional Activities (BCC).

The 3rd EIP result will be achieved by improving coordination and information sharing among the community stakeholders. CBO activities and reporting will link to the community dialogue structure that brings together the COSA (health area health committee), COGE (facility management committee) and the CBOs. The local NGOs will provide continuing training and hands-on mentoring support to the representatives of COSA and COGE. They will train groups on creating strategic and business plans, the technical aspects and quality standards of IMCI/RBM, the methods to assess and monitor health conditions in a community and oversight of health facility drug cost-recovery mechanisms and use of budget allocations.

With guidance from the EIP, the eleven local NGOs will work to change gender bias in the COSA/COGE structures through sensitization activities, and will also share information with the COSA and COGE members on women's influence in changing families' health-seeking behavior. This mix of fact-based discussion and rights-based appeal may change the attitudes of male COSA/COGE members, so that women may

serve as active participants in their decision-making. The local NGOs will also train women's CBOs on their rights and ownership at the health facility pharmacy so that they can hold the COGE accountable for managing the pharmacy. The NGOs will also assist the COSA to fill vacancies promptly and equitably with qualified community representatives.

The eleven local NGOs will also promote the increased participation of representatives of children's groups in the deliberations of the COSA. Representatives from the children's forums, part of Plan's CCCD strategy, can present children's priorities in health and sanitation and also promote healthy behaviors in their families. In the Northwest province, for example, Children's Forums and their representatives have been critical voices for change in getting families to use bed nets, despite parents' reluctance to use nets tinged with smoke from cooking fires.

The COSA representatives, CHRPs and women's CBOs will also identify the destitute living in their communities and then work with the local health center (IHC) through the COSA to arrange free care for these families. After a community-wide meeting where participants define 'destitute poverty' for their community, the CBOs will conduct a wealth ranking assessment, and will employ the definition provided by the community to identify needy families. This group may include widows, OVC and their caretakers, and the elderly. The respective COSA representative will provide those identified as 'destitute' by the community with a tag. This tag will be accepted as adequate proof for exemption at the local health facility.

The community stakeholders will conduct periodic reviews of activities on the community level including the analysis of community behavior maps. Community groups will provide constructive feedback to providers on quality of care based on focus group discussions, open dialogues and exit interviews with clients. Successful strategies will be adopted to improve the program.

District Level: To improve the ability of local health structures and communities to meet the health needs of children in their area, the program will include support and strengthening activities for district level health professionals and local NGOs.

The overall program goal rests largely on the strengthening of health care professionals' knowledge and ability to implement IMCI according to MOH protocols. The program will:

- provide training activities to practicing medical professionals to improve or reinforce their skills,
- support supervisors so that they may ensure the quality of public and private medical facilities,
- disseminate the best practices and lessons learned during the project,
- provide internships for medical students to ensure that the future medical professionals of Cameroon understand and have practical knowledge of IMCI, and
- Reinforce and support community-health facility linkages to improve the quality of care available.

The training for frontline health providers on the standard case management of diarrhea, pneumonia, malaria and malnutrition following the IMCI protocol will target: an 11-day training workshop for new trainees, a five-day training for already trained IMCI

practitioners as future IMCI facilitators, and supportive supervision and follow-up for all trainees on the job. Already a total of four 11-day training IMCI workshops have been conducted in each of the 3 EIP provinces and in Yaoundé for the ProFam providers.

The EIP plans two five-day training sessions for IMCI facilitators and supervisors in each province for a total of 6 in the first year. In each province the first training will train 10 participants drawn from the province who are already trained in IMCI, as facilitators. The second will train these facilitators as supervisors. The ProFam doctor-supervisor will be a trainee during the trainings scheduled for Center province.

With 30 facilitators cum supervisors for IMCI trained within the 3 provinces, MOH will gain a critical mass of skilled staff that will replace costly consultants in conducting subsequent training courses. These staff will also follow -up IMCI trained staff to ensure that they comply with IMCI case management in their daily interactions with sick children in all the 55 health districts of the three provinces.

Within each province the 10 facilitator/supervisors will constitute the provincial IMCI supervisory team (or MOST team) and will coordinate ongoing supervision and on-site refresher courses to frontline staff on a continuous basis. ProFam's doctor-supervisor, who will also provide ongoing support and capacity building, will supervise providers in ACMS' ProFam network trained in IMCI regularly.

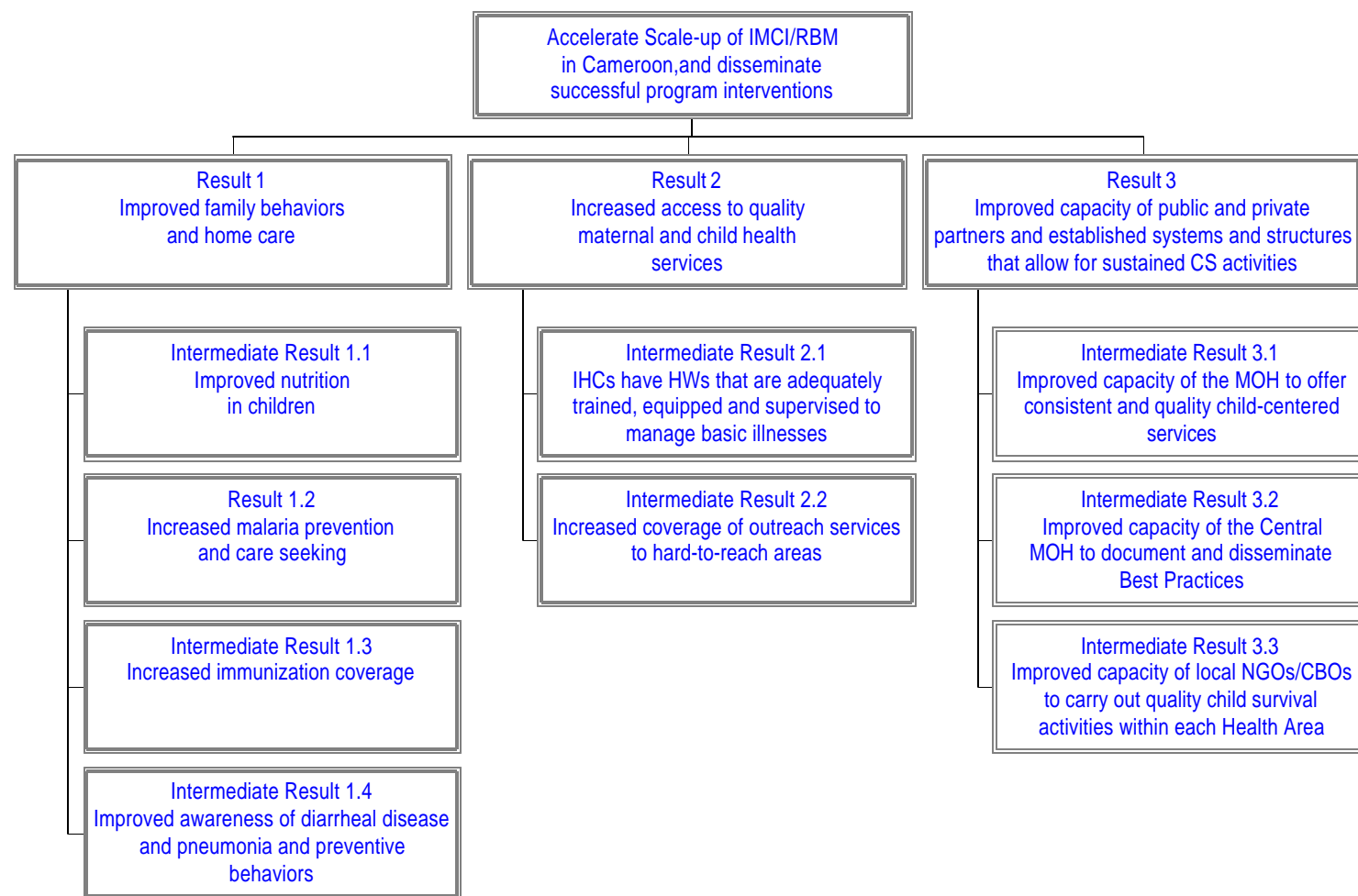
While follow-up supervision and training for IMCI will help the EIP achieve its 2nd result, the strengthened linkages at the district level between the health providers and the community, through the district coordination meetings, will help achieve the 1st and 3rd results. The local NGO, which is EIP's local implementing partner, will actively participate in the District Coordination meetings that are called monthly by the DMO. These meetings have been hosted in the past but stakeholder involvement has been minimal or absent. The local NGO will also be an active player in the elaboration of the District Health Workplan usually done at the end of every year for the following year. The inclusion of district stakeholders to the existing district health platform will provide greater opportunities for sustainable implementation of CS activities. The eleven local NGOs will provide support and follow-up to the activities of the CBOs and CHRPs during their field visits to the villages and will encourage the participation of health facility staff in COSAs and COGEs. Communities will thus express their needs directly to health facility staff, improving patient care and client satisfaction.

Provincial Level: The Provincial IMCI Training Team will establish the Mobile Ongoing Sustainable Training (MOST) unit. MOST units will include a continuing education curriculum for health facility staff and community outreach workers and approach will combine formal seminar-style training and targeted refresher courses, using WHO training videos, DVDs and other tools to increase partner capacity and promote the sustainability of training. Participating public and private health staff will complete an annual IMCI curriculum and will take a pre-test and a post-test in order to maintain IMCI certification. MOST reports will form an integral part of the health systems assessments. Biannual reflection meetings by the Provincial Implementation Committee that is chaired by the Provincial Delegate and brings together stakeholders at that level will document and will communicate best practices and recommendations to the MOH for national IMCI scale-up.

National Level: The EIP seeks to effect policy changes on the national level that will help the MOH adopt standard cutting edge practices in child survival. To best do this the EIP realizes that it has to work with others through partnerships and networks, and to utilize those opportunities to showcase best practices in the 11 target districts. Important players who the EIP will seek to influence are central MOH and the Association of Pediatricians in Cameroon as these are the custodians of current practices around child health. The EIP top Policy organ is the EPC that brings together the executives of Plan, HKI and ACMS and the Director of Family Health of the MOH who reports to the Secretary General for Health. This presents a strategic opportunity to positively influence the MOH. WHO and UNICEF are very strategic partners in this endeavor. UNICEF is also implementing Essential Obstetric Care and Neonatal Health Program in Adamoua Province through the USAID funded AWARE program. A forum that shares best practices in community referral mechanisms for sick community members and home care responses applied to sick infants within the IMCI context is of mutual interest to the EIP and UNICEF. Moreover EIP will work with AWARE, with technical assistance from the BASICS III, to sponsor a visit to DRC by a delegation from Central MOH aimed at promoting the benefits of Community Case Management for Pneumonia. The EIP will work with the RBM committee and with the National IMCI Working Group to provide technical assistance in the scale-up of IMCI and to disseminate lessons learned from each of the 3 provinces. It will provide technical assistance to the MOH in its efforts to prepare and review relevant policies and protocols related to the scale-up of IMCI/RBM. The EIP will also provide technical assistance to the MOH in the preparation of project proposals for the national scale-up of IMCI/RBM. It will explore opportunities of working with the Global Fund Facility to polish proposals and provide needed support for implementing grants. One proposal the EIP hopes to champion for partners to the Global Fund is to seek funding for highly subsidized ITNs in Cameroon. Jointly with the MOH, UNICEF and WHO, the EIP will support the National IMCI Working Group to produce and disseminate best practices in IMCI/RBM. The Working Group will create an annual IMCI/RBM newsletter to present relevant information on cutting-edge technical or implementation issues in Cameroon. The newsletter will be distributed through government, NGO and private channels in the country and the region. The EIP will collaborate with the National IMCI Working Group, MOH, UNICEF and WHO to organize an annual 2-day IMCI/RBM Conference that will present the progress made in the field and delineate the road ahead. The conference will promote discussion on cutting-edge issues, including community-based antibiotic treatment for pneumonia or administration of zinc during and after diarrhea, that have not yet been adopted as national policy. This activity will ensure that both public and private institutions have an outlet to share their best practices to advance the efforts of all partners and contribute towards policy dialogue. During the training and dissemination efforts targeting health professionals, EIP will also work with University students to ensure that future health professionals are trained in IMCI. ACMS will invite medical and nursing students to intern at the ProFam clinics in Yaoundé. Students will intern at clinics run by health staff who have earned their IMCI Clinical Instructor certification. IMCI-certified University faculty will periodically supervise the students throughout their internship program. These faculty members will have comprised part of the team that trained ProFam staff on IMCI, and so their visits will also give an opportunity for follow-up training to ProFam staff. With the University, the

EIP Project Coordinator will also explore opportunities to integrate IMCI training into the standard curriculum for medical students.

Results Framework: Cameroon Expanded Impact Project



Scale and Scale Up Strategy

Scale: The EIP defines scale as the ability of reaching out to more beneficiaries. At the national level, the PVO partners and their existing alliances with local institutions will allow for rapid “quantitative and organizational” scale-up of proven programs and strategies through impacting the existing interventions of the PVO partners. Field Coordinators of Plan Cameroon’s development and capacity building programs will introduce program BCC and best practices into their activities with water management committees, women’s saving/solidarity groups, children’s forums, child-to-child groups and 209 schools with Plan trained teachers which reach out to 64,500 primary school children in the 3 provinces. ACMS’ ongoing theater caravan activities targeting rural areas and network of private vendors and 12,000 supply distribution points will spread positive health messages throughout the country. Similarly, the HKI-supported CDTI distributors will spread these themes to 25 health districts in three provinces initially and to an additional 74 Health Districts in 10 provinces. The projects funded under Plan’s HACI program will promote positive health behaviors to caretakers of OVC. Most importantly, through “political” scale-up, all three PVO partners have a strong working relationship with the MOH, and will support the MOH in her bid for countrywide implementation and new policy to reflect advances in the field and proven successes of the program.

Scaling Up: The key component that the EIP will be scaling up is IMCI and within this will be looking at both the facility (case management and supplies) and community components.

The End Term evaluation of the IMCI pilot phase in the 3 districts of Doume (Plan), Eseka (WHO) and Ngaoundere Rural (UNICEF) was done in March 2005. GOC endorsed the scale up of IMCI. During this time a baseline C-IMCI survey was commissioned by the MOH, which culminated in the holding of the national C-IMCI Strategic Planning workshop on 19th July 2005. MOH adopted 17 key family practices including “active male participation” in addition to the 16 generic WHO behaviors. WHO recommended Plan’s C-IMCI module that had been presented at the WHO AFRO C-IMCI Workshop in Benin in April 2005 as something that could work in Cameroon. The scale up strategy of the EIP will involve a series of 5 steps.

1. Through the IMCI Working Group, EIP will roll out C-IMCI start-up activities. These will include sharing out the C-IMCI toolbox (module) that Plan developed within the previous project for consensus and adoption with the National IMCI Working Group, supporting 3 Provincial Strategic Planning workshops and also supporting 11 District Operational Planning workshops.
2. The Provincial MOST Teams will be formed so that IMCI Case Management Training and supervision can be implemented routinely at Provincial Level. Two five-day training sessions for IMCI facilitators will be conducted in each province for a total of 6 in the first year.
3. Integration of activities between RBM and IMCI will focus on Training and Monitoring/Evaluation. Currently RBM supported Clinical Case Management Training focuses on a 5 day training for all client age groups whereas IMCI Case Management Training focuses on 11 day training for all Childhood Illnesses for client age 0-5. Harmonizing this training will enable RBM to approve regular funding of a portion of IMCI training. Disease classification is also different in the 2 programs. What RBM call Cerebral Malaria is called Very Severe Febrile Disease in IMCI. Harmonizing this reporting will be helpful for both programs.

4. The use of the Malaria competence tool on the community level, which self assesses and tracks malaria community competency trends, will evolve to include assessment and planning for Key behaviors of all EIP interventions.
5. Document and share best practices within EIP's operational area to the National IMCI Working Group

Key Behaviors for the Program

Intervention	Key Area	Behavior
Malaria	ITNs and Retreatment	Children less than five years and pregnant women to acquire an ITN; Retreat ITN every 6 months; Sleep under it every night
	IPT	Pregnant women to swallow a dose of SP during the 2 nd and 3 rd trimester; Attend at least 3 ANC visits during pregnancy
	Case management	Recognize fever and administer treatment within 24 hours; Compliance to IMCI protocol by Health Workers
Nutrition	Breastfeeding	Give colostrum to the newborn child; Initiate breastfeeding within 30 minutes of birth of the child; Breastfeed exclusively for 6 months; Continue breastfeeding for up to 2 years
	Complementary feeding	Begin Complementary Feeding at 6 months; Prepare rich complementary feeds safely; Giving vitamin A rich food daily and adding oil/fat to child diet
	Micronutrients and Deworming	Child above 6 months to swallow Vitamin A bi-annually; Child above 2 years to swallow Mebendazole biannually; Pregnant mothers to swallow IFA during 2 nd and 3 rd trimester of pregnancy and for 6 months after the birth of her child; New mothers to swallow 2 doses of Vitamin A given at least 24 hours apart within the first 8 weeks after birth
	Case Management/ Home Care	Participate in Community Growth monitoring sessions in your community; Giving more fluid and food when the child is sick (more frequent little amounts)
Diarrhea	Hand Washing	To always wash hands with soap/ash after defecating, after toileting a child, before preparation of meals and before eating
	Point of Use Water Treatment	To use chlorination kits; To always store treated water in covered container with narrow neck
	Case Management/ Home Care	Recognition of signs of dehydration; Use of ORS, ORT and Zinc for management of diarrhea
Immunization	Childhood Immunization	Complete Immunization schedule before the 1 st Birthday
	Immunization for Pregnant Mothers	Receive at least 2 shots before the birth of your baby
Pneumonia	Case Management	Recognize fast breathing and chest indrawing; Seek treatment from qualified Provider; Compliance to IMCI protocol by Health Workers

The channels of communication that will be used will include peer education activities and the use of the mass media. Peer education activities are known to raise the awareness of personal risk in the absence of the behavior being promoted and this encourages the adoption of the positive behavior by the peers. Peer education activities will be conducted mainly through CBO contacts and school children. The Hearth Sessions will also provide another opportunity to communicate positive behaviors and not limited to those related to good child nutrition. Mass media is another communication channel that will be used. This is able to reinforce interpersonal communication in promoting positive health behaviors. Caravans of presentations, product demonstrations and promotions by community-based sales agents will also support this.

Quality Improvement Strategy

The quality improvement strategy hinges on the EIP's M/E system that has defined active stakeholder reflection events at 5 levels. Each level will initially define quality as it relates to the set of activities that they do, and will periodically measure this. At the community level CBOs will meet quarterly to analyze their community behavior maps and identify quality gaps that need to be filled.

At the Health Area level the behavior maps from different communities within the health area will be aggregated and this together with facility (IHC) generated information, and health area level LQAS results, will be discussed quarterly by all community stakeholders who include local NGO, COSA/COGE, CBO and MOH. This reflection will allow identification of shortfalls in quality and allow the revision of the action plan for the next quarter to look for opportunities to improve quality.

At the District level the monthly coordination meeting (MIM) that brings all district stakeholders will provide the venue, on a quarterly basis, for discussions and review of the district wide EIP program. Information shared at this level will include aggregated data from all health areas and biannual LQAS and IHFA results. Quarterly coordination meetings at the Provincial level (PIC) and Biannual meetings at the National level (EPC) will also have the added input of biannual LQAS and IHFA results. These meetings will identify lapses in program quality and make recommendations for quality improvement at each level.

Approaches to Increase Coverage

Strategies to involve the community to increase coverage and improve health address current barriers to community involvement. Current barriers include cultural, geographic, knowledge based, and social barriers. To address cultural barriers, socially influential persons, such as grandmothers and religious leaders, in the community and target audiences will be actively involved in the development of value based messages promoting good health practices. Value based messages address underlying cultural beliefs and practices, which hinder greater community participation and the adoption of appropriate health behaviors. Messages will target both the social influencers of behavior and direct beneficiaries.

Accessing the community solely through traditional community and village leaders limits community coverage due to local social and political dynamics, which exclude certain members of a community. Expanding the definition of key persons and involving “alternative” leaders, such as women CBOs, to mobilize community members and disseminate messages will increase program coverage to community members who are not accessible via traditional leaders.

Traditional channels of communication will be expanded upon to include the church and market places. Use of radio and community mass media to disseminate messages will be reinforced. Kye-ele has a community radio station that reaches 100,000 people in the Center Province. Community members will be increasingly involved in and at earlier stages of program development enhancing community ownership. Capacity needs of the community to address their needs will be addressed through activities such as leadership, conflict management, and community coordination training.

Increased access to remote regions will be achieved by prioritization of these areas in program implementation. The use of integrated outreach health services (Health Action Days), and participation of CBOs and local NGOs in opening of more sales points in remotes areas will help the project to reach communities in the remote areas and those living as nomads.

As part of their quarterly meetings community stakeholders will brainstorm practical solutions to address geographic barriers using local human, financial and material resources. For example, such solutions may include the use of locally available materials to construct transportation routes to remote areas.

Equity will be addressed through concentrating efforts on those health areas where the baseline indicators (LQAS) are poorest. Under-served and disadvantaged groups will have access to malaria treatment through CBO mediated efforts to seek waivers for the destitute for cost-recovery at the IHC. Plan Cameroon’s distribution of ITNs to the destitute will also increase equitable access to ITNs.

Sustainability Strategy

EIP defines sustainability as “Maintaining Impact”. Through the CSSA workshop, project stakeholders from the 11 districts collectively identified the major determinants that affect the sustainability of programs in their local context and the achievement of their community vision for health. These determinants stem from what the community perceives to be key health outcomes, quality of health services, local organizational facilitator skills and connectedness, robust community participation and ownership and influential factors of the external environment. They also determined the threats and opportunities that existed towards program sustainability. For example cultural barriers were cited as a major cause for the low uptake of “healthy” behavior within communities. Building the capacity of local organizations in community mobilization skills and knowledge transfer was thus identified as an essential pillar to realize sustainability. The CSSA process defined a total of 45 indicators that it will use to track the sustainability profile. Even more important was the discovery of the need to embrace non-health partners who are critical in realizing sustainability as they play a critical role in stabilizing the environment. Such partners include the Ministry of public works because of its role in

infrastructure development and opening up of the road network. This is viewed as critical for health of the community. EIP drew 11 district-specific dashboards that map up the baseline sustainability profile. They will use this as a discussion tool with district level partners to commit the participation of each partner towards achieving sustainability. EIP plans to collect the indicators again and map another dashboard during the Mid term evaluation to see how far it has come and what it needs to do to give it the best chance to “Maintain Impact” in its program now and beyond.

EIP’s fit into ongoing activities of the partners in the project area

The EIP will allow Plan to meet its Child Survival and Maternal Health Objectives in 11 out of the 12 districts where Plan Operations in Cameroon are located. At the same time EIP activities will reinforce several important areas of Plan’s programming including Child Rights Promotion and Pygmy Rights and Dignity. The EIP will positively influence the community’s capacity to addressing its health needs, which empowers the community to respond to its other needs including community emergencies.

Many of ACMS’ existing programs focus on the EIP project objectives, including: diarrheal disease prevention through national sale of *Orasel* –brand ORS and the *Sûr’Eau/WaterGuard*” water chlorination program; and malaria prevention through targeted behavior change messages over the correct use of ITNs, their re-treatment after six months, IPT and the proper use of the home case management kit. The EIP will also give information on the forthcoming free distribution of nets within the project area by MOH. ACMS works with the private sector commercial distribution system, including the numerous wholesalers, major pharmaceutical wholesalers, and tens of thousands of shops, stands and itinerant vendors as well as pharmacies. This distribution network will ensure the availability of Orasel –branded ORS and Sûr’Eau/WaterGuard solution. ACMS’ promoters will be visiting CBOs during caravan events once every quarter in the project area. Promoters will train CBOs on the use of educational material developed and make sure that this material is available and properly used. The Nutritional Objectives of the EIP fit very well with HKI-Cameroon’s activities including their work in Preventing Micronutrient Malnutrition and especially the community distribution of Vitamin A. The EIP will also strengthen the District Health delivery of healthcare and augment the efforts of the MOH. MOH Cameroon is the chief health authority in the country and the major public provider of basic health services to the poor.

Profile of partners collaborating with the program.

The selection and involvement of the major partners in the design and implementation of the EIP was based on Plan’s past working experience in community based child health activities.

MOH – The MOH is a primary partner that the EIP will work closely with at Health Area, District, Provincial and National Level to strengthen the capacity of the Districts to provide effective services and to improve decision-making and financial management at the IHC level. The MOH manages the health infrastructure of the country and will provide technical and operational support in IMCI, monitoring and evaluation; and supply essential drugs and vaccines to Health facilities.

PSI/ACMS - What makes local PSI affiliate Association Camerounaise Pour le Marketing Social (ACMS) truly unique amongst NGOs is that it also works with the private sector commercial distribution system, including the numerous wholesalers, major pharmaceutical wholesalers, and tens of thousands of shops, stands and itinerant vendors as well as pharmacies. ProFam, ACMS' 25-clinic pilot health center network launched in January 2004, is poised to expand to other areas, notably maternal and child health. Many of ACMS' existing programs focus on the EIP project objectives, including: diarrheal disease prevention through national sale of *Orasel* –brand ORS and the *Sûr'Eau*/WaterGuard chlorination program; and malaria prevention through targeted behavior change messages.

HKI has implemented eye health programs in Cameroon since 1992 and nutrition interventions since 2000 as a partner of the MOH, other non-governmental development organizations and the affected communities. HKI/Cameroon staff includes an expert in assessment, design, implementation, monitoring and evaluation of micronutrient deficiencies control interventions. Many of HKI-Cameroon's activities focus on the EIP program objectives, including their work in Preventing Micronutrient Malnutrition. During 2000 and 2001, HKI provided technical and financial assistance to the National Vitamin A Deficiency and Anemia Survey in order to define the problems of vitamin A deficiency and anemia among pre-school children and women and recommend solutions. In 2002, HKI helped evaluate the effectiveness of the National Salt Iodination Program. HKI staff provided technical and financial support for vitamin A capsule distribution during the National Immunization Days (NIDs) and Sub-National Micronutrient Days since 2002 thereby reaching over 90% of children 6-59 months in 2002 and 2003. HKI has continued to support the MOH by conducting vitamin A coverage surveys and finding alternative delivery mechanisms, such as integrating vitamin A supplementation into community-directed treatment with Ivermectin (CDTI) or delivery of vitamin A via women's groups.

Plan - Currently, Plan Cameroon is operating under a 10-year Country Strategic Plan, in the following development and capacity building: Maternal Health and Child Survival; Food Security and Poverty Alleviation, Pygmy Rights and Dignity, Quality Basic Education, and Child Rights Promotion. Many of Plan's existing activities directly contribute to the goals of the EIP, such as the Participatory Hygiene and Sanitation Transformation program.

Local Implementing Partners: These partners are local NGOs in Cameroon and are district based. Their involvement within the EIP was strategic because being local and district based, they would quickly get the project moving and enhance sustainability.

AAPPEC (Doume and Nguemendouka Districts): The Association for the Self-Promotion of the East Province Population (AAPPEC) has made impressive strides to improve the health and socio-economic status of the Pygmy tribe since the organization's founding in 1972 by the archbishop of Bertoua. With its mission of promoting self-development and peaceful cohabitation and equality of all people of the Eastern Province, AAPPEC implements community-based projects in five program areas: basic education, preventive health practices, gender awareness, agriculture and agro-forestry, and peace and justice. AAPPEC has strong community level relationships because of its field-based approach to development and staff knowledge of local languages and dialects, and was an important partner in Plan's CSXVI project.

KYE-ELE (Esse District): Kye-ele works in four development sectors: Women's development, Education of the Young Girl, Health and Childcare, and Social Communication. The organization encourages women to become economically independent by training in agricultural techniques, management and marketing. Kye-ele provides young girls with education on reproductive health issues and nutrition. Kye-ele also organizes vaccination campaigns and provides information on infant diseases and nutrition. In addition to these programs, Kye-ele owns and manages a rural community radio station to promote program goals with an audience of approximately 100,000 people. Kye-ele has working relationships with HEIFER International, Plan International, the SELF HELP Fund of the American Embassy, UNESCO, and UNICEF.

Local NGOs have the credibility and understanding of local culture that is needed to change intimate health behaviors...their commitment to the area ensures sustainability

Ngoketunjia AIDS fighters (NAFI)(Ndop District): NAFI works in the Ngoketunjia Division and parts of the Bui Division of Fundong District. The organization defines five major focus areas: HIV/AIDS Control and Prevention, Health Support and Promotion, Care of those infected and affected by HIV/AIDS, Process Evaluation and Monitoring, and the Empowerment and Training of persons and groups involved in health promotion and HIV/AIDS prevention. NAFI has been effective in AIDS care, education and prevention through its interactive work at the local level. Through its partnerships, NAFI has set up 22 Local AIDS Control Committees in its region and trained community AIDS educators. It also initiated regular voluntary HIV testing exercises and conducted statistical surveys of HIV/AIDS prevalence rates. NAFI has working relationships with Plan International, the Provincial Technical Group of the Provincial AIDS Control Committee, District Service of Public Health, the Ndop District Hospital, The Baptist Health Board, and major public authorities.

Saints Stephen and Paul's Foundation (SPF) (Bafut District): SPF works in Bafut Health District. The organization has two Activity Areas: Health and Education. Education is targeted at vulnerable groups including the disabled and neglected, and orphans. SPF's health activities include training women's groups on IMCI. SPF focuses on both formal education and vocational training for the disabled and neglected, as well as creating awareness and helping to fight against HIV/AIDS. SPF has working relationships with Plan International.

Meta Cultural and Development Association (MECUDA)(Mbengwi District): With the vision of improving the living standards of the Meta clan, MECUDA intervenes in education, sports, health, agriculture, electricity provision and potable water supply. MECUDA has been sensitizing mothers on the importance of vaccination, breastfeeding, proper weaning, identification and treatment of childhood illnesses and has also been caring for orphans and vulnerable children. It has working relationships with Plan international and the government.

Project Hope – Cameroon (PHC)(Fundong District): PHC works in collaboration with hospitals and health centers in Fundong Health District. Its key areas of work include: hygiene and sanitation, care and support, treatment, capacity building and IMCI. Through the community IMCI approach, PHC seeks to empower and strengthen communities to reduce vulnerability and cope with major epidemics like HIV/AIDS. PHC generates income through income generating projects that include videotaping and photocopying services. Besides these, it also mobilizes resources through community volunteers and other stakeholders in partnership with health facilities. PHC has working

relationships with HEIFER International, Plan International, US Peace Corps and UNICEF.

Awae Centre des Recherches (Awae District): This NGO has the vision of supporting rural communities to better organize themselves in order to handle health and development problems – and giving priority to children and women. It intervenes in education, health, children's rights and income generating activities. ARC has been training CBOs on community IMCI, monitoring children's growth and participating in vaccination activities. It has working relationships with Plan international.

ADEFKA (Batouri District): ADEFKA has the goal of promoting development of women in the Kadey Division of the East Province, Cameroon. It has been training, sensitizing and carrying out field work in the following development sectors: health, education, agriculture and the economy. It has also been an active partner of Plan's Child Survival Project XVI activities in its catchment area. ADEFKA has working relationships with the ministries of Health, Education and Women's affairs, as well as ADEFKA in Holland.

Association for the Fight Against AIDS in Rural Areas (AFAARA)(Fundong District): With the vision of promoting happier, healthier and prospering communities, the Fundong-Based AFAARA seeks to prevent HIV infection, support orphans and people living with HIV/AIDS. It also has interventions in water and sanitation management, as well as child growth-monitoring, vaccination and malaria control. AFAARA has working relationships with Plan international, US Peace Corps and the government (Northwest Province technical group for AIDS control).

GADES (Groupe des Acteurs du Progrès et du Bien Etre Social)(Bertoua District): GADES has the vision of promoting the progress and wellbeing of man and the family as a whole with emphasis on vulnerable members of the community. GADES intervenes in the domains of health, education, sanitation and agriculture, as well as children's and gender rights. GADES has been carrying out social mobilization activities for malaria control and community IMCI and trainings on the positive deviance approach to nutrition. It has working relationships with Plan international and the Ministry of Health.

EMICAM (Doume District): With the mission of promoting childhood health and rights, as well as empowering women, EMICAM focuses on support for orphans and vulnerable children education and health. It also participates in health outreach activities. EMICAM trains and supports women's groups on gender issues and has working relationships with BIT (Bureau international du travail), CICA, Plan International, SOS missionaries, EU, ENDU, Tiers Monde, MAEJT, the Italian ministry of external relations and the CST project.

Other Major Local Partners:

Other major local partners who were consulted and involved in the EIP's program design include WHO and UNICEF (for their role in support for IMCI pilot and scaling up), the faculty of Medicine and Biomedical sciences of the University of Cameroon (for its role in being the major trainer of Health Workers for the country) and the Embassy of the United States in Cameroon.

Roles of major partners

Partners		Roles and Responsibilities
MOH	Health Area	Frontline staff provide case management; Interface with community
	District	Supervisors of frontline staff
	Province	Supervisors of District Health Team; Enforce Health Policy
	Central	Provide essential drugs and equipment; Provide Free ITNs for Children Under 5 and Pregnant Mothers; National IMCI Trainers; Formulate Health Policy; Have a seat in the EPC (top EIP coordinating organ)
Plan		House the EIP staff; Provide overall management support to EIP; Subcontract local NGOs; Provide supervisory support for EIP activities; Convene coordination meetings at all levels; Document and share best practices; Have a seat in the EPC
PSI		Provides health products including Orasel, Waterguard; Distributes and markets these products through the private sector; Develops the “Mothers Booklet” and other educational material over the importance of IPT for pregnant women and the proper use of home case management kits, Document and share best practices; Have a seat in the EPC Train the local NGOs on issues of malaria (Prevention and management) and assist them in the training of the CBOs on malaria community competence.
HKI		Conducts Operation Research on the use of Zinc for Diarrhea case Management; Provides oversight of Nutrition related activities of the EIP including PD/Hearth; Document and share best practices; Have a seat in the EPC
Local NGOs		Responsible for field level activities within the districts; Build the capacity of local CBOs to achieve EIP objectives; Document and share best practices

Plan Cameroon as the Prime PVO to the EIP project has already signed Memoranda of understanding with the other two PVOs (PSI/ACMS and HKI).

The 11 local NGO partners have each submitted a letter of commitment to Plan Cameroon and agreements will be signed with them on approval of the DIP.

EIP Partner Synergy by Intervention

	Malaria	Nutrition	Diarrhea	Pneumonia	Immunization
ACMS	Promotional Materials (Caravans), Advocacy		Promotional Materials (Caravans), Health Products (Orasel and Sur Eau)		
HKI		Promotional Materials, TA, Advocacy	TA for Zinc OR, Advocacy		

Plan/ Local NGOs/ Women Groups	Provision of free nets through a voucher system, Advocacy	Community Growth Monitoring Centers, PD/Hearth	BCC Activities	BCC Activities	BCC Activities
MOH	Policy Development, Case Management, Distribution of 800,000 free nets since 2003.	Policy Development, Provision of Vitamin A, Case Management	Policy Development, Case Management	Policy Development, Case Management	Policy Development, Vaccines

Training plan for the program

Topic	Content	Length	Trainees	Trainer	Methods	Effectiveness Monitoring
IMCI	11-day Frontline Health Worker Curriculum	11 days	Frontline health staff from 11 districts drawn from MOH, Private sector and the Mission Hospital	National IMCI Master trainers	Modular learning, Practical case management observation	Pretest and Posttest, Validation of case management practice
	5-day IMCI Trainer Curriculum	5 days	Provincial and District Medical Officers from 3 provinces- These Trainees will comprise the MOST Team	National IMCI Master trainers	Modular learning, Practical case management observation, co-training during the 11-day IMCI training	Pretest and Posttest, Validation of case management practice, daily “post-mortem” discussions to evaluate learning
	5-day IMCI Supervisor Curriculum	5 days			Modular learning and field supervision of frontline staff practicing IMCI	Pretest and Posttest, daily “post-mortem” discussions to evaluate learning
BEHAVE	5-day TOT Curriculum plus 3 days Doer/non-doer analysis	8 days	EIP staff, DMOs, Local NGOs, COSADI	Plan HQ Backstop	Modular Learning, Field Work	Pretest and Posttest

LQAS	4-day TOT Curriculum plus 4 days of data collection and analysis	8 days	EIP staff, MOH staff, Local NGOs	Consultant, Plan HQ Backstop	Modular Learning, Field Work	Pretest and Posttest
	2-day Refresher	2 days	EIP staff, MOH staff, Local NGOs	EIP HIS Officer	Modular Learning, Question and Answer	Pretest and Posttest
PD/Hearth	11-day TOT Curriculum	11 days	EIP staff, MOH staff, Local NGOs	Consultant, Plan HQ Backstop	Modular Learning, PDI, Field Work	Pretest and Posttest
Community Case Management	CCM Curriculum	10 days	CHRP	MOST Team	Modular Learning, Case management and observation	Pretest and Posttest

CSSA	CSSA Curriculum	4 days	EIP staff, Partners, Community representatives	HQ Technical Backstop	Modular learning, Brainstorming exercises, Groupwork	Pretest and Posttest
HIS	HIS Curriculum	5 days	COSA, COGE, CBO members	EIP HIS Officer, Local NGOs	Modular Learning, Field work, Question and Answer	Pretest and Posttest
	HIS	3 days	District Health Staff	EIP Officer	Brainstorming exercises, Groupwork	Pretest and Posttest
Financial Management	Financial management Curriculum	5 days	COGEs	EIP Finance Officer, Local NGOs	Modular Learning, Question and Answer	Pretest and Posttest

Growth monitoring/ Counselling/ ITN Retreatment	C-IMCI Curriculum, Mother's Booklet	5 days	CBO Members, School Children	EIP staff, District Health team, Local NGOs	Modular Learning, Question and Answer	Pretest and Posttest
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Congruence between EIP, CSHGP and USAID WARP

EIP is consistent with WARP and CSHGP objectives and results as well. The table below shows a comparison of goals, objectives and results.

Linked Strategies and Goals			
CSHGP	EIP Activities	Sample EIP Objectives	WARP
PR1: Improve Health Status of Vulnerable Target Populations.	Will improve facility-based and community-based IMCI/RBM through the combined effort of communities, private and public institutions in 3 provinces; benefits 1999,721 under five children and 454,687 women of reproductive age.	Increase from 11.8% to 50% children age 0-23 months who slept under an ITN the previous night	SO 5 Increased adoption of sustainable RH, STI/HIV/AIDS and child survival approaches in West Africa.
PR2: Increased Scale of Health Interventions.	Promotes lasting behavior change through households, strengthens community-level human resources, involves commercial sector, addresses nutritional component of IMCI/RBM and encourages MOH and private facility response to IMCI/RBM. Integrated into partner development and capacity building programs to facilitate institutional sustainability. Develops community-based model that prevents childhood illness and treats illness through links with the health sector. Supports the District Health Workplan, Work with local and international NGOs, for-profit and non-profit health providers and the commercial sector	80% of the District Coordination Meetings in 8 Districts meet monthly and bring together all relevant stakeholders	IR 5.1 Improved approaches to RH, STI/HIV/AIDS and CS services disseminated region wide,
PR3: Increased contribution of CSHGP to the	Preparation of relevant policies and investment plans, strengthens national networks on IMCI.	The National IMCI and Nutrition Working Groups support the MOH in the	IR 5.2 Increased regional stakeholder advocacy for policy change.

global capacity and leadership for Child Survival and Health.	<p>Work with local and international NGOs, for-profit and non-profit health providers and the commercial sector</p> <p>Provides methods and lessons learned related to national scale-up of IMCI/RBM, strengthens nutrition component of IMCI/RBM at community and health facility levels, and integration within development programming, which has broad application to larger development community. Documents and shares the practice of LQAS and the MOST strategy.</p>	drafting of at least two public policies or protocols related to the scale-up of IMCI/RBM in the country	<p>IR 5.3 Increased capacity of regional institutions and networks.</p> <p>IR 5.4 Health sector reform models developed and disseminated region wide.</p>
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The EIP will involve USAID WARP by requesting their participation at critical moments of the project cycle, such as during DIP preparation and evaluations and also inviting WARP staff to visit the project area. EIP will also work closely with the AWARE program which is a bilateral program funded by USAID. It is supporting the MOH Emergency Obstetric and Neonatal Care through UNICEF and activities are currently focused in Adamawa province that is outside the EIP area. EIP recognizes IMCI as a point of confluence between the EIP and AWARE because of mutual interest of innovative community approaches for referral and management of sick infants. Collaboration between the EIP and AWARE will be strengthened through the fact that planning activities for both programs are centralized within the department of Family Health on the national level. EIP plans to sit in the debrief sessions of EMNC Stakeholders at the national level. This exposure will help EIP in its endeavor to influence health policy through networking. It is hoped that the EMNC program activities e.g. training of health staff in EMNC, will extend to the EIP target districts as Plan is considering investing private funds in this activity in the future.

4. INTERVENTION SPECIFIC APPROACH

The following pages describe disease specific interventions for malaria control (40% Level of Effort or LOE), malnutrition (30% LOE), CDD (10% LOE), Immunization (10% LOE) and pneumonia (10% LOE). The specific interventions of the EIP will prevent illness, promote positive health behaviors and improve access to treatment, as summarized in the Table below.

Summary of EIP Interventions by Age group			
Age group	Prevention	Health promotion	Treatment (Management of illness)
Children under 5	Promotion of the use and re-treatment of ITNs, distribution of vitamin A, ORS, water chlorination kits. Facilitate the distribution of home-based treatment kits for suspected malaria cases. Distribution of zinc supplements during diarrhea, if approved.	Exclusive breastfeeding; micronutrient-rich and cleanly prepared complementary feeding; hand washing with soap; safe excreta disposal; vitamin A administration. Early health care seeking behavior and treatment. Correct use of selected essential health supplies. Timely immunization through IMCI.	Case-management for malaria, diarrhea, and pneumonia according to ICMI/RBM protocols at home and at the health facility. Management of malnourished children through PD/Hearth sessions and the referral of non-respondent cases to health facilities.
WRA (incl. pregnant women)	Promotion of the use of IPT, ITN and distribution of IFA supplements (pregnant women) and vitamin A (post partum women). Facilitate the distribution of home-based treatment kits for suspected malaria.	Early health care seeking behavior and treatment. Correct use of selected essential health supplies, including ORS, and home based treatment kits for suspected malaria. Timely immunization through IMCI.	Management of cases of suspected malaria at home and at the health facility

MALARIA

Overall Objective: Reduce mortality and morbidity due to malaria among children under five years and pregnant women

Specific Objectives for Malaria

Increase from 11.8% to 60% children age 0-23 months who slept under an ITN the previous night

Increase from 15.7% to 60% pregnant women who slept under an ITN the previous night.

Increase from 2.8% to 75% women who completed IPT during their current or last pregnancy

Increase from 11.7% to 60% children age 0-59 months have access to and use recommended anti-malarial within the 24 hours of onset of fever.

Malaria situation in Cameroon

Malaria is an endemic disease throughout the country and is the leading cause of morbidity and mortality. The main parasite is *Plasmodium Falciparum*, which is carried by the female *Anopheles* mosquito. The disease accounts for 50% of morbidity and 40% of mortality among under-five children. According to the DHS III 2004, the under-five mortality rate stood at 144 deaths per thousand and the infant mortality rate at 74 per 1000. Intrauterine malaria causes nearly 10% of registered newborns to weigh less than 2500 grams at birth, placing them at the highest risk of death during infancy.^{xxii} From the EIP KPC (2006), 38.8 % of children had fever in the 2 weeks preceding the survey. Children still die because of lack of early recognition of illness and inappropriate care seeking and treatment. Only 11.7% of children age 0-59 months received a full course of recommended anti-malarial within the 24 hours of onset of fever.

For those presenting to the health facility, the EIP IHFA (2006) reported that assessment tasks for sick children with a history of fever were completed in only 37.5% of children and only 65.4% of malaria cases seen in health facilities received appropriate anti-malarial.

The country has adopted ACT (Artesunate plus Amodiaquine) for home treatment but this is still not readily available. ACT for home treatment is also known as the home kit and will be made available for subsidized purchase through the health facility. In the meantime a non-artemisinin combination of Amodiaquine and Sulfadoxine-Pyrimethamine is in use and can be assessed from the health facility, shops and from local vendors.

With regard to preventive measures EIP LQAS (2006) revealed that 11.8% of children age 0-23 months and 15.7% of pregnant women spent the previous night under an ITN. The MOH distributes nets free of cost to pregnant women and children under five but these nets are too few. This fails to meet the expectations of the beneficiaries. From the FGD, caregivers and CBOs were generally aware of the importance of ITNs in the prevention of

malaria but cited barriers including that ITNs are costly (4000 francs or 8 dollars is expensive and people want it for free), that ITNs produces heat, that the insecticide found in the nets is poisonous to human beings, that the people just don't not know about ITNs (Ignorance), that some people have claustrophobia, that a net looks like a coffin and that people want ITNs but cannot find them (Non availability). The two issues that stand out are those related to Access (cost and availability) and those that relate to acceptability of ITN use.

Eighteen percent of women received at least one dose of SP for IPT during their last pregnancy while less than 2% completed two doses required by MOH policy. IPT is delivered through ANC and the DHS III 2004 reports that 80.2 % of women made at least 2 ANC visits during their last pregnancy.

Key areas being proposed for Malaria prevention and treatment

ITN use and retreatment

IPT

IMCI case management

Activities that will be implemented to achieve project objectives

The overarching EIP strategy for malaria will be to build the competencies of the beneficiary communities within the 11 districts to effectively roll back malaria.

Communities already self assessed themselves using the Community Self Assessment Framework for Malaria Competence tool. This tool, self assesses the current status and the desired target for 14 competency areas (related to malaria) within a community. These competency areas are:

- | | |
|--------------------------------|------------------------------------|
| 1. Fact of Life | 8. Prevention IPT |
| 2. Acknowledgement | 9. Gender Driven Response |
| 3. Inclusion of the Vulnerable | 10. Learning and Transfer |
| 4. Access to treatment | 11. Measuring Change |
| 5. Severe Malaria | 12. Adapting our Response |
| 6. Prevention ITN | 13. Ways of Deploying our Strength |
| 7. Prevention IRS | 14. Mobilizing Resources |

The tool is used as a strategizing and planning tool in that it compares “current” and “target” levels of achievement, prioritizes which targets to aim for first and then strategizes how to reach to that level of competence through the elaboration of an action plan.

Prevention: The EIP will promote the use and re-treatment of ITNs among communities of the project zone through the CBOs by creating appropriate BCC educational materials, training through the local NGOs to the CBOs .. Women's CBOs will organize mass re-treatment campaigns as one of their monthly outreach activities. The EIP will also support the MOH's distribution of ITNs and re-treatment kits to subsidized populations by providing information through CHRPs, women's CBOs and program outreach staff to pregnant women and the families of children under five. EIP will also inform CBOs and communities on forthcoming MOH's free distribution of ITNs. The MOH is planning to distribute free ITNs to every household with an U5 child who will participate in the National Measles Campaign planned for November 2006.

Women CBOs will keep records of “indigent” U5 children who are fully immunized OR up-to-date with immunization and having had births already registered, **who do not have ITNs**, so that they benefit from a free ITN. Pregnant women with demonstrated 1st ANC visit who meet this “livelihoods” criteria will also benefit from a free ITN. Plan will use serialized vouchers donated to these qualifying beneficiaries to claim their free ITN from existing Community Sales Points. Plan will then replenish community ITN stocks, against these utilized vouchers, using private funds.

Emphasis will be placed on the importance of regular re-treatment for sustained health impact.

ACMS will seek separate funding through the Global Fund for subsidized ITN distribution.

Promotion: In households, primary schools, community-groups, CHRs and women’s CBOs, the EIP will promote positive prevention and treatment behaviors for malaria through BCC. Using data from quarterly CBO behavior maps, the malaria community competence framework and biannual LQAS, the partners will design new communication messages to address remaining obstacles to net use and re-treatment. These messages will include information on: the knowledge of the causes of malaria and the different preventive measures available, such as use of ITN and environmental sanitation; who is most vulnerable to malaria infection; the recognition of suspected cases of malaria; the correct administration of the anti-malarial home kit within the 24 hours of the onset of fever; the early recognition of danger signs that merit referral to a health facility; the increased administration of liquids, the continuation of breast-feeding and the maintenance of solid feeding during the disease episode; the organization of a community-based patient referral system using available means of transportation; the importance of IPT and how to access it; the importance and the correct use of an ITN; and the importance and the correct method to re-impregnate an ITN. Messages will be developed by ACMS and will be broadcast nationally.

Treatment: At public health facilities, the MOST trainers and district supervisors will promote the MOH-approved standard case management for malaria in their interactions with staff. This protocol includes the home-based administration of anti-malarial medications, the management of complicated cases and use of IPT for pregnant women. For private facilities, ACMS will promote this protocol through ProFam supervisors. ACMS will also develop educational material on the proper use of those kits. If the environment becomes favorable and funding is made available, the EIP will pilot prepackaged ACT for home-based care through private vendors. Currently this is to be offered through health facilities.

a. Behavior Change & Communication

ITNs and Retreatment

EIP believes that an individual’s behavior is influenced by a number of factors belonging to three broad categories:

Material conditions: Available income, cost of product, access to products

Social support: Cultural, religious and family influences, gender differences

Individual predisposition: personal risk assessment, self efficacy, knowledge on product and perceptions, knowledge on disease and perceptions

A typical set of influencing factors in the context of malaria prevention is:

Awareness of malaria

"I have heard of malaria. It is a disease that is present in this area."

Understanding of transmission

"I know that malaria is only transmitted by mosquito bites. I know that malaria-transmitting mosquitoes bite at night."

Appreciating severity

"Malaria is a disease that can kill. I know malaria is especially dangerous for young children and pregnant women."

Product attributes

"I believe that ITNs can protect me and my family from malaria. I know that I can prevent my child or myself from getting malaria if we sleep under an ITN every night."

Personal risk perception

"My child and I are at risk of catching this disease."

Social support

"People whose opinion I value will support my using and retreating my ITN. It's normal for people like us to use an ITN."

Affordability

"ITNs and retreatment are worth the effort. I know I can afford to obtain and retreat one."

Availability

"I can find an ITN. They are distributed by the MOH and other organizations at places I can reach with a reasonable amount of effort"

Self-efficacy

"I believe that I have the ability to take action in the prevention of malaria. It is important that I convince the economic power-holder in our family that ITNs are necessary. It is vital that I find the means to obtain ITNs for myself and my family and ensure that everyone uses them properly."

In a 2005 survey, PSI found that 50% of rural respondents identified mosquito bites as the only mode of transmission. Other modes mentioned were drinking dirty water and eating certain fruits, particularly mangoes. When asked how to avoid malaria, 91.6 % respondents considered it important to avoid mosquito bites. The same study revealed that

of 91.3% of respondents who have heard about ITN, only about 18% slept under an ITN the previous night.

Information currently in hand suggests that the two issues that affect ITN ownership and utilization and periodic net retreatment, the most are Access (cost and availability) and Acceptability of ITN use. The EIP will also employ the BEHAVE framework to identify remaining obstacles of net use and retreatment by identifying those factors that distinguish those who do the behavior and those who don't.

Key behaviors prioritized under this key area are:

***Children under five and pregnant women always sleep under an ITN
ITNs should be retreated every 6 months***

Existing barriers to these behaviors include the fact that ITNs are not available and that where they are they are very expensive to buy. Mothers said that 4000 Francs is a lot of money for an ITN and that they want nets for free. Some mothers said that ITNs contain an insecticide that is dangerous to human health. The MOH has a policy that provides ITNs free of cost to pregnant mothers and children under five through the health facilities. This is a facilitator of the behavior but the downside is that free nets through various funding mechanisms including the GF and HIPC and Private National Office grants to Plan are few and the demand for them outstrips the supply.

Present BCC materials include PSI-developed IEC and promotional materials, including radio spots, which feature pregnant women and children under five. Studies carried out by PSI (2005/2006) showed interesting impact of these IEC and promotional materials. It was found out that 70% of people exposed to the IEC materials knew where to purchase an ITN against 50% of the non exposed; it was also observed that there was a 21.5% increase in re-treatment knowledge among people as the result of their exposure to the materials; the same study showed that about 96% of people exposed to the materials knew that sleeping under an ITN protects against malaria, which was found to be significant when compared to 90% of those not exposed, who did not know that sleeping under an ITN is a way to prevent malaria occurrence.

The project will utilize a combination of communications channels to reach target audiences. While Mass media may be best for influencing social support, interpersonal communication of generic prevention messages are more effective in increasing personal risk perception. The CBOs will provide the mechanism for the EIP to engage individuals with existing IEC materials. These materials will be validated in light of the baseline survey findings. EIP will aim to use and test available materials first before developing new ones.

The information collected through the community behavior map and the biannual LQAS will inform EIP about unsuccessful BCC approaches. Project staff, Partners and local NGO staff will be trained on the BEHAVE framework within the first year of the project. They will then train the CBOs. Doer/non-doer analysis methods will gather information on behaviors that are critical in mothers and other community member's decision-making and health seeking behavior. Community group sessions facilitated by project staff, local NGO and CBO members will provide an opportunity to discuss and develop tools using

appropriate language and methods. The community will be made aware of the threat posed by malaria as the biggest killer of children and pregnant women in Cameroon. Also children's groups will promote health behavior through messages at the school, community and household levels. In this method, children model priority health behavior taught at school to their siblings and peers in the community.

The matrix below shows an example of one EIP desired health outcome and the targeted audiences, behaviors, influencing factors and activities proposed.

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
Acquisition and use of ITNs	Pregnant Women (WRA),	Acquire ITNs, Sleep under ITNs	Access to free or subsidized ITNs, Acceptability of using ITNs, Other Factors (to be determined by doer non-doer analysis) Poor perception of risk for Malaria, Ignorance or access to information	Individual/ Household: Interpersonal communication Mass media communication
	Caretakers of children under 5	Acquire ITNs, Sleep under ITNs		Community/ Health Facility: Availability of ITNs and retreatment kits, Media campaigns, development of the "New Mother" Booklet, Production of training guides for CBOs, production of audio kits for CBOs
	Husbands, Grandmothers and older children	Support pregnant mother and child to always sleep under ITN	Ignorance or access to information	District/ Provincial: Existence of MOST
	Health Workers	Provide free ITN to pregnant mother and child without expecting a kickback	Factors (to be determined by doer non-doer analysis)	Team that emphasizes regular and supportive supervision of HWs in IMCI compliance, Giving maximum information on free distribution of ITN forthcoming issues National/ Policy: Attracting donors to provide free ITNs

To produce desired programmatic results, a number of challenges must be overcome. Improving malaria awareness and ITN use among women of reproductive age and under-five children in lower density population areas, with fairly limited access to mass media and the commercial sector, presents a significant BCC challenge. Additionally, until subsidized nets become available, the relatively high cost of ITNs will lead many to prefer risking malaria rather than investing in the purchase of what is perceived as an expensive solution. Targeted communications and separate projects to obtain ITN subsidies are aimed at addressing this challenge.

The project is going to reinforce the message on the importance of using ITNs to prevent malaria cases in order to be more useful to the family and the community. Local NGOs will be trained to train and sensitize CBOs and communities on the effects of the disease within the family and the community. The communication strategy of ACMS through its promoters and mass media is already doing this nationally. During year 2 and 3 of the project, ACMS' promoters will be visiting CBOs during caravan events once every quarter in the project area. Promoters will assist the local NGOs to train CBOs on the use of educational material developed and make sure that this material is available and properly used. This material includes information on the importance of IPT and on the timely and proper use of home case management kits.

IPT

The DHS III 2004 reported IPT rates of 2.8% in Northwest province, 1% in the East and 0.5% in the Centre. EIP LQAS 2006 showed that uptake of the 1st dose of IPT is still very low at 18.2%. This is despite the MOH policy that requires that all pregnant women availing of ANC receive SP free of cost during the 2nd trimester (after quickening) and during the 3rd trimester. This treatment is given at least a month apart and is directly observed by the health worker. 80.2% of women attend a minimum of 2 ANC visits (DHS III 2004).

Clearly women availing of ANC service are not receiving IPT as they should and the EIP will conduct formative assessments through the MOST providers to establish the reasons why this is so.

The Key behavior under this key area is:

Pregnant women swallow a complete dose of SP during the 2nd trimester (after quickening) and during the 3rd trimester.

Existing barriers to this behavior include the fact that pregnant women may not be accessing Ante Natal Care or that when they do there is no stock of SP. It is also likely that the Health Worker "forgets" to give SP during this interaction or that the mother does not "remind" the health worker to give the medicine. The major facilitator to this behavior is that it is firmly entrenched in MOH policy and is one of the pillars of the RBM initiative.

The current BCC activities around IPT include sensitization of pregnant women by ANC personnel about the need to take this preventive treatment to protect both them and their

unborn children from malaria. Messages through ANC health personnel have proved to be fruitful in some NW health districts. CBOs will be provided printed educational material informing women on when and where they can get their IPT at no cost. The National malaria control program strategy on IPT did not plan for the production of posters or radio spots. ACMS will develop posters and a radio spot to sensitize over the importance for the pregnant woman to take IPT and to attend at least three quality ANC visits during the pregnancy. ACMS will also provide CBOs with audio kits that include messages about the importance of IPT for pregnant women.. ACMS will also produce prompting stickers to the frontline health staff involved with ANC activities reminding them that IPT with SP must never be forgotten.

The EIP recognizes that increasing the personal risk perception of pregnant women will create demand for and uptake of IPT. Interpersonal communication through CBOs will provide the mechanism for the EIP to engage with pregnant mothers, their husbands and their mothers (or grandmothers).

The matrix below shows an example of the EIP desired health outcome and the targeted audiences, behaviors, influencing factors and activities proposed.

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
Pregnant women swallow SP during the 2 nd and 3 rd trimester	Pregnant Women (WRA)	Attend at least 3 ANC sessions during every pregnancy Swallow SP during the 2 nd and 3 rd trimester	Access to ANC sites, Other Factors (to be determined by doer nondoer analysis), Poor perception of risk for Malaria, Ignorance or access to information	Individual/ Household: Interpersonal communication Mass media communication Community/ Health Facility: Availability of ANC, production of audio kits for CBOs SP, Development of the “New Mother” Booklet District/ Provincial: Existence of MOST Team that emphasizes regular and supportive supervision of HWs in IMCI compliance, IPT provision National/ Policy: Provision of free SP
	Husbands Grandmothers and older children	Support the pregnant mother to attend her scheduled ANC sessions and to remind her about swallowing SP	Ignorance or access to information	
	Health Workers	Provide free SP to pregnant mothers during health contacts	Availability of SP, Existence and use of Job Aids, Other Factors (to be determined by doer nondoer analysis)	

Community Case Management

The ACT home kit for malaria is currently not readily available. EIP KPC 2006 revealed that only 11.7% of children under five received the recommended home kit within 24 hours of onset of fever. The major determinants affecting correct and timely treatment with the ACT home kit is its availability and cost, and the delayed care seeking behaviours of caretakers of young children. The EIP will help local communities conduct operational research using the BEHAVE framework to identify the characteristics of those who appropriately seek care, despite geographic or financial barriers. The community will identify the behaviors of ‘doers’ that are different from ‘non-doers’ despite their similar conditions. The groups will then use information on these characteristics to promote behavior change regarding access to care. Another concern that has been raised about the home kit is the dose (number of tablets), the frequency and the duration of the treatment which people feel is on the higher side. This may be because of the history of the use of Fansidar which was being taken as a one time dose.

The Key behavior prioritized under this key area is:

Children under five receive and begin to use a full course of the ACT home kit within 24 hours of onset of fever.

As earlier alluded, the major barriers to this behavior are the fact that the home kit is not readily available through the public sector where it would be subsidized; and that many households do not activate care seeking mechanisms for childhood fever within 24 hours. The major facilitating factor is the permissive national policy that allows for the existence of ACTs within the community through the health system. Current BCC practices are led by the MOH and emphasis is on home visits carried out by CBOs hired by NMCP to share educative leaflets in households. ACMS will develop educational material to sensitize care givers on the proper use of home kits. This material will be provided to CBOs.

Information collected through the community behavior maps and the biannual LQAS coupled with doer/non-doer analysis will inform about the need to generate and adopt newer BCC activities. The EIP will work with the Malaria Control Program and CENAME at the national level to advocate for the procurement and distribution of home kits within the country.

The matrix below shows an example of the EIP desired health outcome and the targeted audiences, behaviors, influencing factors and activities proposed.

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
Children under five receive malaria home kit within 24 hours of onset of fever	Caretakers of children under five	Recognize fever and access a malaria home kit within 24 hours Begin administering treatment to the child immediately	Cost of Malaria Home kit, Other Factors (to be determined by doer non-doer analysis) Poor perception of risk for Malaria, Ignorance or access to information	Individual/ Household: Interpersonal communication Mass media communication Community/ Health Facility: Availability of malaria home kit, Development of a community referral procedure, the "New Mother" Booklet, posters, availability of Audio kits for CBOs District/ Provincial: Existence of MOST Team that emphasizes regular and supportive supervision of HWs in IMCI compliance, Use of ACT as 1 st line National/ Policy: Provision of subsidized home kits for malaria
	Community Groups	Poor solidarity mechanisms within the community	Poor solidarity mechanisms within the community	
	Health Workers	Use ACT for 1 st line treatment of Malaria, Maintain adequate stocks of ACTs in the Health facility	Availability of ACT, Existence and use of Job Aids, Other System Factors	

b. Quality Assurance

The goal of the National Malaria Control Program as stated in the five-year Strategic Plan for Cameroon 2002-2006 (PSNP) and in accordance with RBM guidelines is to reduce by half the morbidity and mortality in under-fives and pregnant women in Cameroon. This will be accomplished through eight strategic objectives:

Strengthening malaria case management
Malaria prevention activities
Promotion of malaria control through IEC and advocacy
Epidemiological surveillance
Management and administrative processes
Development and implementation of operations research
Development of partnerships to combat malaria
Strengthening institutional capacity

Community level (e.g. environmental management) and household-level (e.g. use of ITNs) activities are recognized as the major interventions needed for reducing malaria-

related morbidity and mortality, particularly among the most vulnerable pregnant women and under-five children. Also effective case management in the home and health centers will reduce malaria mortality. This ties in with the three pillars of RBM: a) global partnership, b) high-level political support, and c) community-level activities.

Considering the large need for community case-management in the country, PNLP plans to dedicate 83% of its efforts to promotion IEC through CBOs and local NGOs (PSNP Strategic Objective 3- To promote activities towards the fight against malaria at all level).

Malaria is endemic throughout the country, and PNLP considers that most inhabitants have at least one attack of malaria annually, though many receive no treatment for it. The EIP KPC 2006 showed that 33.8% of children had fever in the 2 weeks preceding the survey. National health policy for malaria stresses training health personnel in efficient diagnostic and treatment techniques (including IMCI), maintaining the supply of antimalarial (including malaria home kit), and increasing malaria awareness nationwide (BCC).

The Strategic Plan has the following ambitions: 60% of under five children with fever / malaria will receive correct treatment within 24 hours of the onset of the fever, 60% of under five children will sleep under ITN; 60% of pregnant women will sleep under ITN; and 75% of pregnant women will receive anti-malarial IPT

Given the growing resistance of *Plasmodium falciparum* to Chloroquine, the first line treatment is now Artesunate and amodiaquine as ACT used in home based and facility-based treatment. The MOH recently also reinstated IPT for pregnant women with Sulfadoxine Pyrimethamine to be provided free of charge.

How the EIP will define, measure and improve quality

The EIP program will be implemented at 5 levels. These are the Community Level, Health Area, the Health District, the Provincial Level and the National Level. The EIP has assembled a coordination team which brings stakeholders together and which will sit regularly to analyze program findings and to make recommendations about what needs to be changed. A mechanism is in place to propose changes to scheduled activities on the local level on the strength of the analysis of information at their level.

At every level the coordination team will use consensus to define quality on each key program area. Perhaps a local Health Area may decide to peg 25% as their quality standard for ITN use by children during the 1st year. Measurement of quality will be made possible in part by the application of biannual monitoring assessments through the LQAS and the MOST tools. The MOST tools have been adapted from the Health Facility Assessment, and will be able to provide quantitative results about IMCI compliance. These assessments will provide biannual information specified by Health Area that the coordination team would be able to reflect about and propose improvements. At the community level, the Community Behavior maps will be used to provide quarterly updates on the behavior profiles of the community, which will inform quality improvement activities. At the district level an aggregation of the LQAS, MOST and Community Behavior maps from all the Health Areas within the district will inform the coordination committee about how the EIP is doing in respect to achieving its quality targets and what needs to be done to make this continue to happen.

To ensure proper quality assurance there is need for constant follow up of agreed activities, training of both health care providers and care givers and availability of products/services.

Investing in supervision as a project activity will ensure follow up activities within the EIP. These supervisions will help providers identify gaps and therefore improve health providers' and caretaker skills.

Quality assurance will also be ensured through “mysterious clients” surveys especially within the ProFam facilities.

Current Supervisory System

The current supervisory system is very top down and is weak in articulating decisions at the implementation level without the express blessing from the top. Currently, Health Area supervision by the District Health Team is conducted monthly; the provincial health team conducts district supervision quarterly and the central level supervises the Provincial Health team biannually. However, this system is encumbered with difficulty, making it irregular, due to lack of resources in terms of qualified staff and logistics. Supervision on the community level is weak.

With the EIP in Cameroon, the provincial level will support the 10 member MOST team (mobile ongoing sustainable training) which will conduct quarterly visits to health facilities and maintain IMCI certification for providers who have already undergone the standard 11-day IMCI training. The EIP will also support district health teams in carrying out proper and regular supervisions of both health services and community level activities. This it will do through promoting stakeholder involvement and buy-in in the elaboration of the district Workplan that is done at the end of every year, and by providing logistic support. Supervision shall be a budgeted activity and this will ensure that it is done. The EIP will provide support to the Local NGOs for CBO supervision by factoring compensation of staff time spent on supervision on their sub-agreements.

The EIP's monitoring and evaluation plan that allows for stakeholder biannual reflection of the program following the LQAS and IHFA will strengthen the existing supervision system.

Tools to Promote Quality of Service

Many tools already exist in Cameroon and the EIP will not try to re-invent the wheel. The adapted IMCI/RBM Training manuals for health care providers are already available and will provide the point of reference for checklists related to clinical performance. Community level curricula and tools that relate to Community-IMCI are still in development and the EIP will assist the National IMCI Working group of the MOH to finalize these tools.

Malaria treatment protocols and net treatment guidelines have been developed by the National Malaria Control Program and are currently being used by the program to improve the quality of malaria case management and net treatment.

The EIP will invest in the MOST tool which will be an aggregate tool that allows for a quality supervision at the health provider level.

At the community level the Community Self Assessment Framework for Malaria Competence tool will be used. This tool, developed by the Constellation for AIDS Competence, headed by Jean-Louise Lamboray, self assesses the current status and the desired target for 14 competency areas (related to malaria) within a community. Built into this tool is a presentation diagram called “river and stairs” that allows multiple communities to recognize those “competency areas” that they still need to work on and from whom (amongst their peers) they have an opportunity to learn from.

Availability of Health Related Products

The MOH is responsible for all drugs, supplies and equipments in the public health facilities. Drugs are procured through CENAME. The National Laboratory that is affiliated to MOH does quality control. Currently CENAME is able to save up to 40% of the market costs through bulk purchasing. CENAME then distributes the drugs and supplies to the public health system, which the public is able to access through cost recovery. EIP IHFA 2006 showed that 7% of the essential medicines needed were out of stock on the day of the survey. The EIP will strengthen drug quantification/stock management efforts at the health facility level by liaising with CENAME and CAPPs which are the central and provincial drug procurement offices respectively.

The private sector is another important source of health related products but the costs of these are usually beyond the majority of the population. A very vital function of the private sector however is social marketing, which has proved very successful in increasing coverage of products at a subsidized cost.

The majority of the population in the project area live on less than a dollar a day and only 11.8% of children and 15.7% of pregnant mothers slept under an ITN during the night prior to the survey. MOH will continue to distribute ITNs at no cost targeting pregnant women and children under five using HIPC and Global Fund resources. The EIP will contribute to this by giving maximum information on forthcoming issues of free distribution of nets by the MOH. Currently the availability of free nets is grossly outstripped by the demand for these nets by those who need them for free. Plan Cameroon with private funding from some of its national offices will also assure supply of ITNs and net treatment to WRA in the intervention areas free of cost. ACMS has been actively soliciting ExxonMobil for subsidies for rural areas for the next round of project activities. ACMS is also preparing a proposal to the Global Fund for heavily subsidized nets to be distributed to women of childbearing age. The EIP project area has 200,000 under fives today, and with a projected 160,000 pregnancies during the life of the project (2010), does have a net need of 520,000 over the LOP for children U5 and pregnant women. However only about 30,000 pieces (of 1.1 million pieces available for 7 provinces) will be available for distribution in the 11 districts this year through the Measles Campaign.

The availability of ACTs used for home kits; SP for IPT, ITNs and retreatment kits will be vital supplies for this intervention. There are presently funding concerns about the procurement of the ACTs, but the GOC is addressing this through funding received from the 5th cycle of the GF.

In addition health services through ACMS' ProFam network and the eleven health districts will implement malaria case management among children under five and IPT among pregnant women.

The supply of anti-malarial to the eleven health districts will be assured by the national system of essential drugs (CENAME). Currently procurement of SP is stable and where it has been absent is more a question of distribution from the central stores than its lack. ACTs on the other hand are available in the private market but the cost is out of reach to most of the population. CENAME will procure ACTs and offer them cheaply to the public through cost recovery once funds become available.

Likely constraints to the success of "supply-dependant" activities may include:

- Difficulties for the supplier to respect the procurement time frame.
- Stock out at the supplier level.

To overcome these constraints, EIP will develop partnership with other pharmaceutical wholesalers supplying malaria commodities both locally and internationally and will continue to be an active member of the RBM committee.

All drugs distributed by the National System on Essential Drugs are systematically tested for quality by an established MOH National laboratory for quality control. EIP will ensure that all drugs used in the intervention areas are procured through the National Drug Procurement System.

The insecticide kit for net treatment marketed by ACMS is always accompanied by relevant communication on safety measures. The notice found with each treatment tablet informs the user that remaining water, gloves and unused packaging should be disposed off into pit latrines or buried.

c. Access to services

ITNs and Retreatment

Access to ITNs and ITN re-treatment kits is difficult for many families. The EIP will assist the MOH by sensitizing mothers of under-five children to get ITNs at no cost during measles campaigns and other free distribution issues. The EIP will also promote the re-treatment of ITNs every six months during the Health and nutrition action weeks. To achieve this, the project will create appropriate BCC materials to educate the community on the importance of ITNs, their proper use, and net re-treatment. The health districts, through the local NGOs, the CBOs and health committee members, will organize mass re-treatment campaigns as one of their **main** activities of the health and nutrition action week. Community level re-treatment of nets will be available for 500-600F per net. Health Action weeks, women gatherings, religious movements and market days will also be used to sensitize on the need to use ITNs to prevent malaria. It will also increase community ownership for subsequent re-treatment of ITNs.

The destitute or indigent population will be targeted with free ITNs through a variety of sources. This is in keeping with MoH policy of providing free ITNs to pregnant women and children below five. The MOH distribution mechanisms will ensure that all pregnant

women and children below five receive ITNs. Plan Cameroon has limited private sources to distribute free ITNs in some of the districts.

IPT

Health providers through CBOs and CHRPs community HIS will maintain updated lists of those who are currently pregnant within their jurisdictions. CBOs and CHRPs will encourage pregnant women to attend ANC services available in the health facility of the catchments area or the outreach post. IPT for pregnant women will be administered through ANC. MOH recommends that pregnant women receive at least 3 quality ANC visits during the entire pregnancy. According to the recent national policy, SP is given free of cost to pregnant women at least twice, the first dose in the second trimester (after quickening) and the second during the third trimester. Integrated Outreach health services will be carried out in hard to reach areas and this will ensure equity in access.

Malaria case management

Community level: CBOs, CHRPs and caretakers will be trained on home case management. Home treatment kits, which comprise Artesunate/Amodiaquine, will be made available through health facilities at a subsidized price. A pharmaceutical company, Aventis-Sanofi, is in the process of launching a newer combination of this formulation in Cameroon that will reduce the number of tablets that have to be swallowed. Home treatment kits will also be part of the integrated outreach health services medicines kit. Health Facility Level: At the health facility level, EIP will train health workers on the national IMCI protocol and assure adequate drug supplies to improve community access to effective malaria treatment. The MOST team will monitor the quality of care provided at the health facility. Interventions at the several levels will minimize frequent drug stock-outs. Facility staff will master minimum re-order levels for drugs and immediately notify the District health Office. The district health team will spearhead the rapid distribution of drug kits once they become available from CENAME. District MOH will define monthly drug requirements for each facility following analysis of facility utilization and drug use per IHC, and share these findings with the Provincial Delegate and other stakeholders. It will also explore opportunities for local drug redistribution within district public health facilities if some facilities are found to be “over-stocked”. At the provincial and national level, CENAME will be invited to the coordination meetings which will advocate the need to individually tailor regular drug stock in the regions based on individual facility need as reported by the DMOs.

Equitable Access

The use of integrated outreach health services, CBOs and local NGOs will help the project to reach communities in the remote areas and those living as nomads. Through these channels, under-served and disadvantaged groups will have access to malaria services including treatment. Plan Cameroon’s targeted distribution of ITNs to the destitute (the indigent population) in some districts will also increase equitable access to and use of services. Efforts will be concentrated on those health areas where baseline indicators are poor and the hard to reach areas. Gender equity to accessing services will be emphasized through BCC and a key message will be that all members of the household need to sleep under an ITN without any discrimination.

NUTRITION

Overall Objective: Reduce mortality and morbidity due to malnutrition and anemia among children under five years and pregnant women

Specific Objectives for Nutrition

Increase from 50.8% to 75.8% children age 0-5 months who were exclusively breast-feeding during the last 24 hours.

Increase from 80.9% to 90% children age 6-59 months who received Vitamin A supplementation in the prior 6 months.

Increase from 21.6% to 80% mothers giving birth in the last 12 months who received two vitamin A supplements within 8 weeks post partum.

Increase from 9.2% to 30% sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.

Nutrition situation in Cameroon

Breastfeeding and complementary foods: Cultural beliefs are amongst the major factors affecting nutritional behavior especially in regard to breastfeeding. Colostrum is considered dirty and therefore harmful to the newborn. While waiting for the full withdrawal of colostrum and the flow of mature breastmilk, a variety of prelacteal feeds are given including sugar and water. EIP KPC 2006 showed that 50.8% of mothers of children 0-5 months were exclusively breastfeeding their children. Exclusive breastfeeding is hampered by beliefs about the effect of sexual relations on the quality of breastmilk, and the insufficiency of breastmilk alone to meet the nutrition needs of the child. Complementary foods are given early and may not be nutrient dense. Mothers fear that weaning the child later than two or three months may encourage the child to refuse to accept the community staple later (EIP FGD 2006). 33.8% of children 6-9 months received food rich in oil in the previous 24 hours while 65.4% of the same cohort received food rich in proteins (EIP KPC 2006).

Micronutrients: Although 80.9% of children 6-23 months received Vitamin A supplementation in the last 6 months, only 21.6% of mothers received 2 mega doses of Vitamin A within 8 weeks post partum (EIP KPC 2006). Low accesses to IFA and low compliance to IFA supplementation among pregnant women affect the health of mother and child. DHS III 2004 revealed anemia prevalence of 51% among pregnant women. In the same study Anemia prevalence for lactating women was 43.6% and the prevalence for low birth weight was 12%.

Case Management and PD/Hearth: Nutritional rehabilitation at the community level is still at its infancy in Cameroon. Plan has initiated PD/Hearth in a few places with successful results. PD/hearth was able to help children gain up to 1200 grams in the first round. Health Worker practices related to the assessment and management of nutrition related morbidity in sick children is still wanting. Proportion of sick children who had their nutrition status correctly assessed was 8.7% (EIP IHFA 2006). While 85.8% of children were weighed as part of the clinical visit, only 25.3% of children had their weights entered

into a growth chart to assess status. Also only 33.7% of the caretakers were counseled by the HWs on continuing to give food or breastfeeding at home. EIP KPC 2006 showed that 9.2% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.

Key areas for Malnutrition prevention and treatment

Breastfeeding and Complementary Foods

Micronutrients

IMCI case management & PD/Hearth

Activities that will be implemented to achieve project objectives

To achieve the project objectives, the following majors interventions will be implemented:

- Nutrition counseling for behavior change. This will target Breastfeeding and Weaning.
- Micronutrient supplementation. This will also target deworming of children (24-59 months),
- Community-based nutritional rehabilitation

Community Level: Community Growth Monitoring will be the basic entry strategy of EIP's nutrition activities on the community level. Women CBOs and CHRP's will enlist and involve children and their mothers in these sessions. Key messages promoted at this level will include: the giving of colostrum; exclusive breast-feeding during the first 6 months of age (**or for 4 months with a rapid weaning of 1 week for HIV + mothers**); the administration of micronutrient-rich, protein-rich and safely prepared solid or semi-solid weaning foods at 6 months of age; continued breastfeeding for at least 24 months; the promotion of micronutrient-rich foods to pregnant and lactating women, the administration of vitamin A supplements every 6 months among children aged 6 months to 5 years; the use of IFA to prevent anemia among pregnant women; the administration of two mega-doses of vitamin A to puerperal women; the adoption of behaviors to prevent diarrheal disease like hand washing (including ensuring follow-up with zinc supplementation for 10 to 14 days in severe cases); to complete the full immunization schedule before the child is one year of age; giving fresh fruits daily; and the increased administration of liquids, the continuation of breast-feeding and the maintenance of solid feeding during a disease episode.

Vitamin A supplementation activities will be carried out during immunization campaigns through HKI CDTI distributors. Supplementation activities will also be conducted in the context of growth monitoring sessions and Health Action Days (in hard to reach areas). Deworming medicines to children above the age of 2 years will be given biannually at these sessions. Pregnant mothers and those who have recently delivered will receive IFA. The goal is to have pregnant mothers take IFA during the 2nd and 3rd trimester and during exclusive breastfeeding. The EIP will stress the importance of marking supplementation activities on children's immunization or growth monitoring cards and mothers monitoring cards so as to link with the health facility information system.

Communities with at least 30% of mild, moderate and severe malnutrition will be eligible for PD/Hearth intervention. In the selected communities, the women's CBOs will select one to two volunteers to serve as the PD/Hearth facilitators. Local NGOs will train the volunteers in the implementation of the PD inquiry and on conducting community-based nutritional rehabilitation sessions. Immediately after training, the facilitators will conduct

the PD inquiry. Children who are identified as mildly to severely malnourished will be invited to participate in the nutrition rehabilitation Hearth sessions. During the rehabilitation session, the facilitator will de-worm children and provide them vitamin A supplements supplied by the MOH according to national protocol, noting each supplement on their immunization or growth monitoring card. The facilitator will also encourage the use of local foods that are already rich in needed micronutrients, as well as the specific feeding and care behaviors identified during the PD inquiry. Caregivers will bring a daily contribution of food or materials that they have available to the sessions, which will be used in the preparation of nutritious meals. Since PD/Hearth emphasizes the use of low-cost or no-cost foods and broadens the scope of what communities consider food products, even those caretakers living in absolute poverty will be able to join the sessions. The Hearth sessions will be conducted for 10-12 days within a two-week period, after which children will be weighed. After finishing the sessions, the facilitators will visit participants' homes for two weeks in order to ensure an average of 21 days of practice. The EIP will provide technical support to public and private health facilities with the capacity to help children who do not respond to the PD/Hearth intervention. The PD/Hearth facilitator will refer these children to the designated facility in the catchment area for further evaluation and treatment. The PD/Hearth facilitator will provide information on children in the session, such as supplementation activities, to the local COSA representative for further delivery to the health facility.

EIP and its local NGOs will gradually phase in the PD/Hearth program in the 11 community-focused districts. During year 2, communities will conduct PD/Hearth in two villages in Nguemendouka, as part of a consultant led effort to train TOTs in PD/Hearth, after which the program will conduct one village per district per year, for a total of 11 villages annually. An evaluation will be done early in year 3 and will allow the local NGOs, EIP partners and government to learn from the successes and weaknesses of the program. During project years 3 to 5, the program will use the lessons learned to implement PD/Hearth in at least three villages per district per year, for a total of 99 villages during the last three years of the program.

Community members will be encouraged to use iodized salt as North West and East provinces are classified as high iodine deficiency zones. Kits for testing iodine content of salt will be provided by MOH to CBOs.

Health Facility/District Level: Health Facilities will employ the Baby Friendly Hospital Initiative, which seeks to improve breastfeeding rates. IMCI-trained health providers will also counsel mothers on the breastfeeding technique and facilitate the administration of two mega-dose VACs, 24 hours apart, to each new mother within eight weeks of the birth of her child. EIP will capitalize on the child visits made within the 1st 6 to 8 weeks to the facility to target at least 80% of these mothers. ANC sessions within and without the facility will provide opportunity to counsel and prepare pregnant mothers for breastfeeding.

During visits to public and private health facilities, MOST trainers will cross check and support on nutritional assessment of sick children and nutritional counseling given to caretakers during case observation.

National Level: The EIP will profile Exclusive Breastfeeding coupled with initiation of breastfeeding within half hour of birth, nationally. It wishes to link breastfeeding with the message of immunization. Integrating breastfeeding within the national Immunization Program will promote exclusive breastfeeding for 6 months and continued breastfeeding for 2 years by emphasizing the following messages

- Infants who never breastfeed miss their first immunization and are much more likely to die
- Infants who do not exclusively breastfeed to 6 months receive a less potent immunization
- Children who do not breastfeed for at least two years do not receive their full immunization coverage
- Not breastfeeding, partially breastfeeding, or early weaning may reduce the impact of other immunizations

At the national level the EIP will support the National Nutrition Working Group (NNWG), which will serve to coordinate efforts and promote integration of nutrition interventions and messages into all possible venues and programs.

a. Behavior Change & Communication

The key issue about nutrition in Cameroon involves the practices that surround breastfeeding. These include colostrum feeding, early initiation of the child to the breast, exclusive breastfeeding, continued breastfeeding up to 24 months and the need to continue breastfeeding even if the mother has commenced sexual activity. The EIP will employ the BEHAVE framework to help design an appropriate BCC strategy during the first year. It will identify those factors that distinguish those who practice the desired breastfeeding behaviors and those who don't. An analysis of these factors and a critique of existing communication channels available to care providers that influence their attitudes and practices, will help to identify materials, messages and mediums that will be best suited to reach the audience.

The Key behaviors under this key area are:

Mothers should give colostrum to their newborn child

Mothers should initiate breastfeeding within half an hour of birth

Mothers should exclusively breastfeed their child for 6 months

Mothers should continue breastfeeding their child up to 24 months

Existing barriers to these behaviors have to do with cultural beliefs that hold dear to both men and women. This includes the belief that child malnutrition is due to exclusive breastfeeding, having sexual intercourse during breastfeeding or witchcraft. In order to prevent child malnutrition, families may have the child wear protective amulets, ensure that the mother avoids sexual intercourse while breastfeeding, or provide complementary foods to children earlier than three or four months of age. Plan has found, however, that grandmothers who are informed participants in the community health structures have a very positive effect on younger mothers. For example, several young mothers who had not participated in health education activities testified during the final evaluation of the CSXVI project that they learned many positive attitudes and behaviors from trained grandmothers, including exclusive breastfeeding for the first six

Family decision making

In Cameroon, young brides move into their new husband's family home. When they begin their own family, their mother-in-law provides advice and guidance in child-care. Young women place a high priority on the advice of their mothers-in-law, even if they have learned of other child care practices outside the home. These mothers-in-law, or 'grandmothers,' are included in all BCC activities of this program.

months and vaccinating their children following the immunization schedule.^{xxiii}

Breastfeeding Support groups with the support of older women on the community level and visible encouragement from the local health system for these support groups will go a long way to dispel myths surrounding breastfeeding within the communities.

Current BCC messages about breastfeeding include posters within health facilities.

Breastfeeding counseling is also given by IMCI trained health workers during sick child visits and to pregnant women during ANC visits. Support from the MOST team for HWs to mainstream breastfeeding counseling is necessary. The women CBOs will provide the mechanism for the EIP to engage mothers about their breastfeeding habits and the dangers posed to their children. The information collected through the community behavior map and the biannual LQAS will inform EIP about unsuccessful BCC approaches. Doer/non-doe analysis methods following BEHAVE training will gather information on the major determinants that determine breastfeeding behaviors. Community group sessions facilitated by project staff, local NGO and CBO members will provide an opportunity to discuss and develop tools using appropriate language and methods. Children's groups will also promote breastfeeding messages at the community and household to their siblings, peers and mothers in the community.

The matrix below shows the targeted audiences, behaviors, influencing factors and activities proposed

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
Mothers with children below 6 months to exclusively breastfeed their children	Mothers of children under 6 months and Pregnant Mothers	Recognize that Breastmilk is sufficient nutrition for the child and the its first immunization and thus offer the breast to the child within half an hour after birth Breastfeed on demand and know how to correctly latch a child to the breast.	Beliefs about the safety of colostrum and sufficiency (or insufficiency) of breastmilk, Other Factors (to be determined by doer nondoer analysis), Ignorance or access to information	Individual/ Household: Interpersonal communication, Breastfeeding support groups Community/ Health Facility: Development and use of “New Mother” Booklet District/ Provincial: Existence of MOST Team that emphasizes regular and supportive supervision of HWs in IMCI compliance. National/ Policy: Effective linkages of Breastfeeding Messages with the National Immunization Program
	Community Groups	Support mothers to offer only breastmilk to their children within the 1 st 6 months	Poor solidarity mechanisms within the community	
	Health Workers	Mainstream Exclusive Breastfeeding counseling at all opportunities where contact is made with WRA within and without the health facility.	Existence and use of Job Aids, Other System Factors	

b. Quality Assurance

Discuss MOH policies, strategies and/or case management policies or current services for each intervention.

The National Nutrition Policy specifies that Nutrition education, Micronutrient supplementation and Nutritional rehabilitation must form the key elements of the National Nutrition Program which has now been validated. The National Nutrition Program has also incorporated the administration of Zinc for the management of diarrhea.

How the EIP will define, measure and improve quality

The EIP program will be implemented at 5 levels. These are the Community Level, Health Area, the Health District, the Provincial Level and the National Level. The EIP has assembled a coordination team which brings stakeholders together and which will sit regularly to analyze program findings and to make recommendations about what needs to be changed. A mechanism is in place to propose changes to scheduled activities on the local level on the strength of the analysis of information at their level.

At every level the coordination team will use consensus to define quality on each key program area. Perhaps a local Health Area may decide to peg 60% as their quality standard for Exclusive Breastfeeding by children between 0-5 months during the 3rd year. Measurement of quality will be made possible in part by the application of biannual monitoring assessments through the LQAS and the MOST tools. The MOST tools have been adapted from the Health Facility Assessment, and will be able to provide quantitative results about IMCI compliance. These assessments will provide biannual information specified by Health Area that the coordination team would be able to reflect about and propose improvements. At the community level, the Community Behavior maps will be used to provide quarterly updates on the behavior profiles of the community, which will inform quality improvement activities. At the district level an aggregation of the LQAS, MOST and Community Behavior maps from all the Health Areas within the district will inform the coordination committee about how the EIP is doing in respect to achieving its quality targets and what needs to be done to make this continue to happen.

To ensure proper quality assurance there is need for constant follow up of agreed activities, training of both health care providers and care givers and availability of products/services.

Investing in supervision as a project activity will ensure follow up activities within the EIP. These supervisions will help providers identify gaps and therefore improve health providers' and caretaker skills.

Current Supervisory System

The current supervisory system is very top down and is weak in articulating decisions at the implementation level without the express blessing from the top. Currently, Health Area supervision by the District Health Team is conducted monthly; the provincial health team conducts district supervision quarterly and the central level supervises the Provincial Health team biannually. However, this system is encumbered with difficulty, making it irregular, due to lack of resources in terms of qualified staff and logistics. Supervision on the community level is weak.

With the EIP in Cameroon, the provincial level will support the 10 member MOST team (mobile ongoing sustainable training) which will conduct quarterly visits to health facilities and maintain IMCI certification for providers who have already undergone the standard 11-day IMCI training. The EIP will also support district health teams in carrying out proper and regular supervisions of both health services and community level activities. This it will do through promoting stakeholder involvement and buy-in in the elaboration

of the District Workplan that is done at the end of every year, and by providing logistic support. Supervision shall be a budgeted activity and this will ensure that it is done. The EIP will provide support to the Local NGOs for CBO supervision by factoring compensation of staff time spent on supervision on their sub-agreements. The EIP's monitoring and evaluation plan that allows for stakeholder biannual reflection of the program following the LQAS and IHFA will strengthen the existing supervision system.

Tools to Promote Quality of Service

The adapted IMCI Training manuals for health care providers are already available and will provide the point of reference for checklists related to nutrition clinical performance. The EIP will invest in the MOST tool which will be an aggregate tool that allows for a quality supervision at the health provider level. Community IMCI tools are currently being developed by the National IMCI Working group and will be used on the community level. The National Vitamin A Supplementation Protocol provides clear guidelines about how Vitamin A should be administered. It is however in need for revision within the emerging context of HIV which results to children not being breastfed. The CORE developed PD/Hearth manual will be the key reference to operationalizing the hearths.

Availability of Health Related Products

The MOH is responsible for Vitamin A, Iron/Folic Acid and Mebendazole in the public health facilities. Currently only Vitamin A is provided for free at the point of use. Drugs are procured through CENAME. The National Laboratory that is affiliated to MOH does quality control. Currently CENAME is able to save up to 40% of the market costs through bulk purchasing. CENAME then distributes the drugs and supplies to the public health system, which the public is able to access through cost recovery. EIP IHFA 2006 showed that only 7% of the essential medicines needed were out of stock on the day of the survey.

Cameroon has been admitted into the Global Deworming Initiative and will be receiving 5 million doses of Mebendazole from Johnson & Johnson for free distribution to school children in the next four years.

c. Access to services

Access will be facilitated through referral of beneficiaries by use of Community Based Registers maintained by CBO members. Pregnant women, recently delivered mothers who are within 8 weeks postpartum, children under six months of age and their mothers will be specifically targeted through a variety of community activities including community growth monitoring sessions, Health and Nutrition Action Week and during ANC clinics. The MOH policy provides Vitamin A free of cost. Health Workers will reach postpartum mothers who bring their children for Immunizations.

DIARRHEA

Overall Objective: Reduce mortality and morbidity due to Diarrhea among children less than five years

Specific Objectives for Diarrhea

Increase from 7.7% to 30% (from baseline value) mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.

Diarrhea situation in Cameroon

Hand Washing: EIP KPC 2006 baseline results show that only 7.7% of caretakers washed their hands before preparing food for a child, before feeding a child, after changing the diaper of a child who has defecated and after the caretaker returns from defecating. Some caretakers do not wash their hands after defecating because they use paper or leaves to tidy themselves up and do not believe that it is necessary to wash hands which have not had direct contact with stool. This information, revealed by focus group discussions, suggests that BCC is necessary to increase the proportion of caretakers who regularly wash their hands.

Point of Use Water Treatment: ACMS has just received approval from the Ministry of Trade to zero-rate tax on these kits and is in the process of launching social marketing for “Sur’Eau/Waterguard”.

None of the mothers surveyed during the baseline survey was using chlorination kits to treat water.

Case Management (ORS and Zinc): According to the DHS III 2004, the prevalence of diarrhea in children 0-23 months was 25%. On the national level, ORS is used in only 23%^{xxiv} of cases. A KPC Survey executed by Plan Cameroon in these three provinces in 2004 found that only 14-16% of mothers used ORS in the latest diarrhea episode of their children. While ACMS has been distributing ORS in Cameroon since 1994, project efforts on promotion have been very limited because of funding constraints. A new Low-osmolarity ORS formulation launched by UNICEF has generated heated discussions within the Central MOH because of inconclusive evidence about its efficacy in managing epidemic diarrheas like cholera.

The MOH approves the standardized case management of Diarrhea through the IMCI protocol. This protocol supports the management of simple diarrhea in the home by using ORS. The MOH does not support the use of the Sugar-Salt solution in lieu of ORS. EIP IHFA 2006 showed that only 38.7% of sick children with a history of diarrhea had assessment tasks for diarrhea completed. 38.3% of those with simple diarrhea received ORS/RHF (It was higher in the Center Province and East Province at 61.5% and 58.3% respectively where IMCI training had been provided to health workers). The IMCI guidelines also prohibit the use of antibiotic for diarrhea. Proportion of children with

simple diarrhea who received an antibiotic or an antidiarrheal was 78.3% (It was 92% in the North West Province where Health Workers are yet to receive IMCI training).

The MOH is currently analyzing the implications of the recent WHO/UNICEF policy statement on the administration of zinc supplements during and after a diarrhea episode.^{xxv} While Zinc supplements have been shown to reduce the severity and duration of diarrhea and protect against new occurrences for up to 6 months, it is not yet being used for treatment in Cameroon. The MOH is very supportive of the pilot assessment that will be done by the EIP through HKI in 3 districts.

Key areas for Diarrhea prevention and treatment

Hand Washing

Point of Use Water Treatment

IMCI case management (ORT and Zinc)

Activities that will be implemented to achieve project objectives

Prevention: EIP will work with teachers and Children's Forums in Plan-supported schools throughout the 11 target districts to create and share messages on hygiene and sanitation. The Children's Forums, part of Plan's CCCD strategy, will promote hand-washing with soap and inform how often hand-washing is required. In addition to hand-washing and use of latrines, CHRP and CBOs will educate households on water and sanitation techniques such as home water chlorination and solar disinfection, or "sun-boiling," all low cost, feasible, effective and sustainable strategies. Households will be taught about storing treated water in covered narrow-neck containers. Increased access to safe water supply and basic sanitation through CHRP activities and ACMS' Sur Eau and Orasel distribution and promotion will facilitate a comprehensive strategy for diarrhea control.

The EIP will also promote Exclusive breastfeeding until a child is six months as it reduces the incidence of diarrhea; and the distribution of Vitamin A because it has a demonstrated effect on the prevention of diarrhea.^{xxvi}

Promotion: The EIP will promote positive health behaviors related to diarrhea prevention and case management in households, primary schools and community-groups, and through CHRPs and women's CBOs. These messages will include: the knowledge of the causes of diarrhea; the importance and the correct use of breast-feeding, nutritious and safely prepared complementary feeding, hand washing at critical moments (after defecating, before eating, after changing diapers and before preparing meals), safe disposal of excreta and safe food preparation for diarrhea prevention; the early recognition of danger signs that merit referral; the chlorination of drinking water using ACMS chlorine sachets; the increased administration of liquids, the continuation of breast-feeding and the maintenance of solid feeding during disease episodes; and the administration of ORS.

Treatment: At the community level CHRPs will stock ORS and will administer home treatment for Class A diarrhea. At the province and health facilities level, the EIP will promote the MOH-approved standard case management for diarrhea cases included in the IMCI protocol. This protocol does not currently include the administration of zinc during and after the diarrhea episode. HKI will work with the National IMCI and Nutrition Working Groups and an expert zinc consultant to design a pilot strategy to test the use of zinc to treat and prevent the reoccurrence of diarrheal disease for children 12 – 59 months of age as part of the IMCI package in Cameroon. The pilot will be implemented in one health district per province in the first year and scaled up to all 11 EIP-focus health

districts by the third year after an evaluation of the pilot program. In this study, women's CBOs and COSA members will be trained to follow-up daily with caretakers in their homes to ensure adherence 10 to 14 day treatment. HKI and the MOH will develop training modules and materials based on a qualitative study. Training of health providers will be integrated into the IMCI training curriculum. Zinc supplements will be made available through private funding by HKI and treatments provided according to current WHO protocol. Based on the results of the pilot study, the EIP will promote the dialogue within the National IMCI and Nutrition Working Groups to initiate the application of the recent WHO/UNICEF policy recommendation that supports these strategies throughout Cameroon.

At commercial outlets and private health providers, the EIP will facilitate the distribution of ACMS' brand Orasel –brand ORS and Sur Eau home chlorination through private-sector commercial outlets and health providers, and will create appropriate materials to accompany the products. ACMS will also begin an integrated communication and sales effort to market the products together in rural areas where access to clean water is especially problematic, and in regions that have historically experienced outbreaks of cholera and other water-born illnesses. With ACMS and local NGO training, private providers will know how to counsel their clients on the use of ORS and the home management of diarrhea.

a. Behavior Change & Communication

The practice of hand washing is a major element that drives the prevalence of childhood diarrhea in Cameroon. The EIP will employ the BEHAVE framework to help design an appropriate BCC strategy during the first year. It will identify those factors that distinguish those who practice the desired hand washing behaviors and those who don't. An analysis of these factors and a critique of existing communication channels available to care providers that influence their attitudes and practices, will help to identify materials, messages and mediums that will be best suited to reach the audience.

The Key behaviors under this key area are:

Mothers should wash their hands with soap/ash before food preparation

Mothers should wash their hands with soap/ash before feeding children

Mothers should wash their hands with soap/ash after defecation

Mothers should wash their hands with soap/ash after attending a child who has defecated

Mothers should give ORS and continue giving their child more foods and fluids during recovery

Existing barriers to these behaviors are related to cultural beliefs. This includes the belief that there is no need to wash your hands if your hands did not get into direct contact with stool while using leaves or toilet paper. Current BCC messages about Handwashing are school based and shared to students by their teachers. The women CBOs will provide the mechanism for the EIP to engage mothers about their hand washing habits and the dangers posed to their children. The information collected through the community behavior map and the biannual LQAS will inform EIP about unsuccessful BCC approaches. Doer/non-doer analysis methods following BEHAVE training will gather information on the major determinants that determine hand washing behaviors. Community group sessions

facilitated by project staff, local NGO and CBO members will provide an opportunity to discuss and develop tools using appropriate language and methods. Children's groups will also promote hand washing messages at the community and household to their siblings, peers and mothers in the community.

The matrix below shows the targeted audiences, behaviors, influencing factors and activities proposed

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
Mothers with children below 5 years wash their hands with soap and water before preparing meals, before feeding children, and after toileting both themselves and their children	Mothers of children under 5 years of age	- Mothers should wash their hands with soap/ash before food preparation - Mothers should wash their hands with soap/ash before feeding children - Mothers should wash their hands with soap/ash after defecation - Mothers should wash their hands with soap/ash after attending a child who has defecated	Cost of portable water and soap for hand washing, Other Factors (to be determined by doer nondoer analysis), Ignorance or access to information	Individual/ Household: Interpersonal communication Community/ Health Facility: Development and use of "New Mother" Booklet , Availability of soap and water District/ Provincial: To profile the importance of Handwashing with soap and water through Inter-school challenges/sports activities National/ Policy: To encourage water related infrastructure and soap subsidies
	Grandmothers and Children	Support mothers to always wash hands with soap/ash	Access to information, Other Factors (to be determined by doer nondoer analysis)	
	Fathers	Enable mothers to have access to soap and water for washing hands	Cost of Soap, Other Factors (to be determined by doer nondoer analysis)	

b. Quality Assurance

The IMCI guidelines currently guide the case management of Diarrhea in Cameroon. A classification of diarrhea with one of 3 levels of dehydration is made and defines how the child should be managed. Rehydration and the administration of Vitamin A is the backbone of the treatment. Antibiotics are only to be given in a classification of dysentery and antidiarrheal agents are prohibited. The IMCI algorithm does not include Zinc at the moment but the MOH and the National IMCI Working Group are open to add Zinc following operational research that will be done by HKI within the EIP program. The National Nutrition Program has also incorporated messages about the importance of Zinc administration in the management of diarrhea.

How the EIP will define, measure and improve quality

The EIP program will be implemented at 5 levels. These are the Community Level, Health Area, the Health District, the Provincial Level and the National Level. The EIP has assembled a coordination team which brings stakeholders together and which will sit regularly to analyze program findings and to make recommendations about what needs to be changed. A mechanism is in place to propose changes to scheduled activities on the local level on the strength of the analysis of information at their level.

At every level the coordination team will use consensus to define quality on each key program area. Perhaps a local Health Area may decide to peg 15% as their quality standard for Mothers washing their hands with soap (before feeding, before preparing meals, after defecating and after toileting their child) during the 2nd year. Measurement of quality will be made possible in part by the application of biannual monitoring assessments through the LQAS and the MOST tools. The MOST tools have been adapted from the Health Facility Assessment, and will be able to provide quantitative results about IMCI compliance. These assessments will provide biannual information specified by Health Area that the coordination team would be able to reflect about and propose improvements. At the community level, the Community Behavior maps will be used to provide quarterly updates on the behavior profiles of the community, which will inform quality improvement activities. At the district level an aggregation of the LQAS, MOST and Community Behavior maps from all the Health Areas within the district will inform the coordination committee about how the EIP is doing in respect to achieving its quality targets and what needs to be done to make this continue to happen.

To ensure proper quality assurance there is need for constant follow up of agreed activities, training of both health care providers and care givers and availability of products/services.

Investing in supervision as a project activity will ensure follow up activities within the EIP. These supervisions will help providers identify gaps and therefore improve health providers' and caretaker skills.

Current Supervisory System

The current supervisory system is very top down and is weak in articulating decisions at the implementation level without the express blessing from the top. Currently, Health Area supervision by the District Health Team is conducted monthly; the provincial health team conducts district supervision quarterly and the central level supervises the Provincial

Health team biannually. However, this system is encumbered with difficulty, making it irregular, due to lack of resources in terms of qualified staff and logistics. Supervision on the community level is weak.

With the EIP in Cameroon, the provincial level will support the 10 member MOST team (mobile ongoing sustainable training) which will conduct quarterly visits to health facilities and maintain IMCI certification for providers who have already undergone the standard 11-day IMCI training. The EIP will also support district health teams in carrying out proper and regular supervisions of both health services and community level activities. This it will do through promoting stakeholder involvement and buy-in in the elaboration of the District Workplan that is done at the end of every year, and by providing logistic support. Supervision shall be a budgeted activity and this will ensure that it is done. The EIP will provide support to the Local NGOs for CBO supervision by factoring compensation of staff time spent on supervision on their sub-agreements. The EIP's monitoring and evaluation plan that allows for stakeholder biannual reflection of the program following the LQAS and IHFA will strengthen the existing supervision system.

Tools to Promote Quality of Service

The adapted IMCI Training manuals for health care providers are already available and will provide the point of reference for checklists related to nutrition clinical performance. The EIP will invest in the MOST tool which will be an aggregate tool that allows for a quality supervision at the health provider level. Community IMCI tools are currently being developed by the National IMCI Working group and will be used on the community level. The National Vitamin A Supplementation Protocol provides clear guidelines about how Vitamin A should be administered. The Zinc Operational Research will also refine guidelines for the administration of Zinc in Diarrhea case management.

Availability of Health Related Products

The MOH through CENAME and ACMS provide ORS at a small cost to the user. ORS is readily available. Zinc is not currently on the MOH essential drug list. The current formulation is Nutriset and will be procured by HKI, using private funds, for purposes of the operational research. Vitamin A is provided for free at the point of use.

c. Access to services

Behavior change communication activities will be based on the community level through the CBO members and the school children. Access to case management will be facilitated through CHRPs. Based on the baseline results, the project will identify those supervision areas with poorly faring indicators and allocate more effort and resources to. The project will also identify the hard to reach areas and develop specific strategies, including regular HADs, to ensure active community participation.

PNEUMONIA

Overall Objective: Reduce mortality and morbidity due to Pneumonia among children less than five years

Specific Objectives for Pneumonia

Increase from 37.7% to 67.7% children with signs of severe childhood illness who were seen by a qualified public or private provider in the past 2 weeks.

Pneumonia situation in Cameroon

A majority of the acute respiratory infections are viral, mild, and self-limiting. Most children with ARI do not need antibiotics. In fact, the use of antibiotics for common colds and coughs is not only inappropriate and costly, but may also accelerate the emergence of resistant bacteria. SCM (Standard Case Management) of children with ARI seeking care from health workers is important from the perspective of quality treatment and rational drug use. The DHS III 2004 revealed that the prevalence of pneumonia in under-five and 0-23 month children was 11% and 15% respectively.

EIP KPC 2006 showed that **75.2%** of children 0-23 months in the Northwest province experienced rapid or difficult breathing, while **66.7%** of children experienced these symptoms in the Center and **42.4%** in the East provinces. Only half or 51.9% of sick children presenting with a history of ARI had all ARI assessment tasks completed according to the EIP IHFA 2006. Also the proportion of pneumonia cases that received an appropriate antibiotic was 20.7% and proportion of children with simple URTI (Upper Respiratory Tract Infection) who received an antibiotic was 70.8%.

Concerned about developing antibiotic drug resistance, the MOH does not currently approve of community-based use of antibiotics in pneumonia case management by Community Health Workers.

Key areas for Pneumonia prevention and treatment

Recognition of Pneumonia and Prompt Referral

IMCI case management

Activities that will be implemented to achieve project objectives

Prevention: Through IMCI training and supervision, and regular outreach efforts including HAD, the EIP will promote and facilitate childhood immunization with measles and pertussis (pentavalent vaccine-DPT+Hib+ HepB) vaccination for all eligible children. Timely immunization is one of the few preventative activities for pneumonia. Exclusive breastfeeding will also boost the immune system and reduce the incidence and severity of pneumonia infection.

Promotion: In households, primary schools and community-groups, and through CHRPs and women's CBOs, the EIP will promote: information on the causes of pneumonia and the importance of breast-feeding and nutritious and safely prepared complementary feeding for its prevention; the early recognition and prompt referral of suspected cases of

pneumonia; the increased administration of liquids, the continuation of breast-feeding and the maintenance of solid feeding during the disease episode; the importance of timely immunization; and the organization of a community-based patient referral system using available means of transportation.

Treatment: At public and private health facilities, the EIP will promote the MOH-approved standard case management for pneumonia included in the IMCI protocol. The MOH-approved standard case management for pneumonia does not currently include the community-based administration of antibiotics. The EIP will promote the dialogue within the National IMCI Working Group to initiate the application of the recent WHO/UNICEF policy recommendation that supports this strategy. Should the MOH come to support community-based administration of antibiotics, Plan will work with MOH and the local NGOs to train CHRPs and women's CBOs on how to follow-up with those taking antibiotics to ensure compliance with the full drug course.

a. Behavior Change & Communication

Quick recognition and prompt careseeking for pneumonia to certified providers will be a key element in the EIP strategy. The EIP will employ the BEHAVE framework to help design an appropriate BCC strategy during the first year. It will identify those factors that distinguish those who practice the desired care seeking response and those who don't. An analysis of these factors and a critique of existing communication channels available to care providers that influence their attitudes and practices, will help to identify materials, messages and mediums that will be best suited to reach the caretakers of young children.

The Key behaviors under this key area are:

Mothers should recognize fast breathing and chest indrawing as signs of pneumonia in their child

Mothers should promptly seek for care from a qualified Health Worker for their child

Mothers should make their child complete the treatment provided

Mothers should continue giving their child more foods and fluids during recovery (Breastmilk only if child is less than 6 months)

Existing barriers to these behaviors are related to cultural beliefs and to the cost of seeking for care outside the home. Most communities believe that a child who presents with a cough, fast breathing and chest pain has been pricked by the whiskers of a lion by a sorcerer and will need to involve in a ritual that will deliver it from that sorcerer. There current BCC materials for pneumonia from the MOH are outdated as they were developed prior to the adoption of IMCI. EIP will work with women CBOs and school children to counsel mothers about adopting these behaviors. The information collected through the community behavior map and the biannual LQAS will inform EIP about effectiveness of BCC approaches being applied in the different Health Areas. Doer/non-doe analysis methods following BEHAVE training will gather information on the major determinants that determine pneumonia-recognition and referral behaviors. Community group sessions facilitated by project staff, local NGO and CBO members will provide an opportunity to discuss and develop tools using appropriate language and methods. Children's groups will

also promote pneumonia messages at the community and household to their siblings, peers and mothers in the community.

The matrix below shows the targeted audiences, behaviors, influencing factors and activities proposed

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
To reduce the deaths of children through Pneumonia	Mothers of children under 5 years of age	Mothers would recognize pneumonia and promptly refer children to appropriate provider	Failure to recognize signs of pneumonia out of lack of knowledge, cost for care-seeking, Other factors (to be determined by doer/non-doer analysis)	Individual/ Household: Interpersonal communication Community/ Health Facility: Development and use of “New Mother” Booklet, Community Referral System in place, IMCI Training and supervision District/ Provincial: Strengthen health facility supportive supervision National/ Policy: To encourage pilot for community administration of antibiotics
	Grandmothers and Children, Fathers	To help to recognize pneumonia in children and assist in initiating prompt referral		
	Other Community Members			
	Health Workers	To initiate IMCI case management	Lack of drugs and supplies, Lack of training	

b. Quality Assurance

To address the problem of pneumonia, WHO developed a Standard Case Management (SCM) protocol, which enables peripheral health workers to detect childhood pneumonia based on a few clinical signs, without the use of a stethoscope, chest x-ray, or laboratory facilities. This approach is now an integral part of IMCI adopted by the MOH and which is being scaled up within the context of the EIP. The current position of the MOH with regards to community use of antibiotics in the management of pneumonia is clear and restrictive. However, in the course of this project, EIP will invite the MOH and the National IMCI Working Group into discussions about the implications of the recent WHO/UNICEF policy statement recommending the administration of antibiotics by community health workers (CHRs).

How the EIP will define, measure and improve quality

The EIP program will be implemented at 5 levels. These are the Community Level, Health Area, the Health District, the Provincial Level and the National Level. The EIP has assembled a coordination team which brings stakeholders together and which will sit regularly to analyze program findings and to make recommendations about what needs to be changed. A mechanism is in place to propose changes to scheduled activities on the local level on the strength of the analysis of information at their level.

At every level the coordination team will use consensus to define quality on each key program area. For Pneumonia the quality standard at the community level may be “that 50% of children with signs of pneumonia promptly referred to the Health Facility” during the 2nd year. Measurement of quality will be made possible in part by the application of biannual monitoring assessments through the LQAS and the MOST tools. The MOST tools have been adapted from the Health Facility Assessment, and will be able to provide quantitative results about IMCI compliance. These assessments will provide biannual information specified by Health Area that the coordination team would be able to reflect about and propose improvements. At the community level, the Community Behavior maps will be used to provide quarterly updates on the behavior profiles of the community, which will inform quality improvement activities. At the district level an aggregation of the LQAS, MOST and Community Behavior maps from all the Health Areas within the district will inform the coordination committee about how the EIP is doing in respect to achieving its quality targets and what needs to be done to make this continue to happen.

To ensure proper quality assurance there is need for constant follow up of agreed activities, training of both health care providers and care givers and availability of products/services.

Investing in supervision as a project activity will ensure follow up activities within the EIP. These supervisions will help providers identify gaps and therefore improve health providers' and caretaker skills.

Current Supervisory System

The current supervisory system is very top down and is weak in articulating decisions at the implementation level without the express blessing from the top. Currently, Health Area supervision by the District Health Team is conducted monthly; the provincial health team conducts district supervision quarterly and the central level supervises the Provincial Health team biannually. However, this system is encumbered with difficulty, making it irregular, due to lack of resources in terms of qualified staff and logistics. Supervision on the community level is weak.

With the EIP in Cameroon, the provincial level will support the 10 member MOST team (mobile ongoing sustainable training) which will conduct quarterly visits to health facilities and maintain IMCI certification for providers who have already undergone the standard 11-day IMCI training. The EIP will also support district health teams in carrying out proper and regular supervisions of both health services and community level activities. This it will do through promoting stakeholder involvement and buy-in in the elaboration of the District Workplan that is done at the end of every year, and by providing logistic support. Supervision shall be a budgeted activity and this will ensure that it is done. The EIP will provide support to the Local NGOs for CBO supervision by factoring compensation of staff time spent on supervision on their sub-agreements.

The EIP's monitoring and evaluation plan that allows for stakeholder biannual reflection of the program following the LQAS and IHFA will strengthen the existing supervision system.

Tools to Promote Quality of Service

The IMCI protocol will form the reference guide to guide the quality of case management for pneumonia at the facility level. MOST supervision will directly observe health worker practice and caretaker exit interviews to assess whether sick children presenting with pneumonia have received appropriate treatment. Review the Under 5 outpatient register in health facilities will monitor pneumonia case management. Local NGO health promoters and CBOs members will be trained in the steps of pneumonia case management using the C-IMCI guideline that is still in development.

Availability of Health Related Products

Within the IMCI protocol, the MOH recommends a first line antibiotic (cotrimoxazole) for the treatment of children with pneumonia, in the absence of which a second line drug (Amoxicillin) is recommended.

These drugs are readily available in the health facilities through CENAME. The trouble is having the MOH accept to having these drugs accessible to the households within the communities. On the other hand, failure to give a correct dose of antibiotics, or complete a course of treatment in children with pneumonia, will increase the risk of treatment failure and the development of antibiotic resistance. Thus, The challenge is getting oral antibiotics to all children who need them, and then treating effectively (with the right drug, at the right time), while avoiding the use of antibiotics in children who do not need them.

c. Access to services

Utilization of health services tends to decrease with increasing distance from health providers. There is also a relationship between distance from a facility and delays in seeking treatment. If visiting appropriate providers involves substantial costs in time or money, then child caretakers are unlikely to promptly seek care, even if they recognize signs of pneumonia. Caretakers frequently use home remedies or untrained providers such as traditional healers or drug vendors. Care from trained providers is often sought only after the initial treatment has failed or when signs of more severe disease are recognized. A delay in starting effective treatment for pneumonia will increase the risk of death. The project will support the district health teams and the Integrated Health Center staff to organize or revamp outreach activities within the context of the minimum package of services.

The MOH-approved standard case management for pneumonia does not currently include the community-based administration of antibiotics. The EIP will promote the dialogue within the National IMCI Working Group to initiate the application of the recent WHO/UNICEF policy recommendation that supports this strategy

Equitable access

Based on the baseline results, the project will identify those supervision areas with poorly faring indicators and allocate more effort and resources to. The project will identify the hard to reach areas and develop specific strategies, including HADs to enlist active participation.

Referral Systems for severely ill children will be reviewed and strategies developed to improve referral practices if necessary. The EIP will continue to seek opportunities to influence the MOH on the necessity of allowing a limited and supervised Community based administration of Antibiotics for purposes of learning.

If at any point the MOH comes up with a policy to support community-based administration of antibiotics, the EIP will work with local NGOs to train community health workers and women's CBOs on how to follow-up with those taking antibiotics to ensure compliance with the full drug course.

IMMUNIZATION

Overall Objective: Reduce mortality and morbidity due to Vaccine preventable diseases

Specific Objectives for Immunization

Increase from 70.5% to 80% children 11-23 months who are fully immunized.

Increase from 58.9% to 80% mothers of children 0-23 months who received 2 TT during last pregnancy

Immunization situation in Cameroon

The EIP KPC 2006 gave full Immunization coverage of 70.5% for children 11-23 months. EPI figures for national immunization coverage for 2005 was 79.6%(DTCHeP3) suggesting that the EIP program area is below the national average. Coverage for 2TT for mothers was 58.9%.

EIP IHFA 2006 revealed the proportion of children who had vaccination card checked at sick child visit was 53% and the proportion of mothers who had vaccination card checked at the time of sick child visit was only 6.4%. The proportion of children needing an immunization that received it on the day of the visit or referred for vaccination on another day was 48%.

Cultural beliefs including girl child infertility, access (geographical and financial), ill health of the child (fever) and ignorance about the importance of immunization were some of the reasons why caregivers (parents) do not take their children for vaccination (EIP FGD 2006).

The MOH policy provides childhood and maternal immunization free of charge in every health facility and in outreach posts.

Key areas for Immunization

Full Immunization coverage by the first birthday

Activities that will be implemented to achieve project objectives

Household/Community Level: Activities shall center on Surveillance activities and Behavior change communication targeted at the whole community but specifically to skeptics and those whose coverage is low. Key messages will include the need to have the child fully immunized by the first birthday and that pregnant mothers need two Tetanus shots before the birth of their baby to protect both the baby and themselves. The community shall be made aware that five tetanus doses are considered adequate to provide lifetime protection for women. Households need to understand that immunizing a child protects the child as well as other children the child may come into contact with. With the advent of the NIDs people question why a child who was previously immunized still needs to be immunized again and this gives opportunity to skeptics to spin rumors against the real intentions of immunization. Through regular growth monitoring sessions in the community, CBO members will map their villages and get to know those children that are due for immunization and where to concentrate BCC efforts. This will help to strengthen referrals for immunization as well as position these children for the service during HADs.

BCC will present the attributes of immunization in preventing disease and in making the child generally stronger to fight off other infection. Pregnant mothers will be targeted to avail of at least 3 ANC visits during their pregnancy. School children will also present messages to their peers, siblings and mothers. Every mother and child shall be encouraged to maintain vaccination cards and to use it as a record of health events at every opportunity with the health service.

Health Facility/District: Activities at this level will employ the IMCI rigor to screen all children presenting to the health system for immunization status and provide the required immunization at that time. Missed opportunities account for a big proportion of children who miss out on their immunization. The COGE representatives and the Health Worker shall make periodic reconciliations of community based data and Health Facility based data to update immunization coverage and plan HADs as appropriate. The MOST Team will strengthen IMCI implementation at the facility level through supportive supervision and maintaining adequate supplies.

National Level: At the national level efforts shall concentrate on supporting districts with adequate vaccination supplies.

a. Behavior Change & Communication

Those caretakers who miss to have their children fully vaccinated by the first birthday usually fail to see the importance of this status for their child. Such failure could be because caretakers do not know (because the child is not sick) or that they fail to perceive the risk their children are exposed to. The EIP will employ the BEHAVE framework to help design an appropriate BCC strategy during the first year. It will identify those factors that distinguish those who get their children fully immunized by the first birthday and those who don't. An analysis of these factors and a critique of existing communication channels available to care providers that influence their attitudes and practices, will help to identify materials, messages and mediums that will be best suited to reach caretakers.

The Key behaviors under this key area are:

All children should be fully immunized by their first birthday

All pregnant mothers should receive 2 Tetanus Toxoid shots before the birth of their child

Existing barriers to these behaviors are related to rumors that have been generated in the recent past linking immunizations with sterility especially of the girl child. Current BCC messages about Immunization include radio spots and other mass media campaigns through the NIDs. At the community level women CBOs will provide the mechanism for the EIP to engage caretakers about full immunization status of children by their first birthday. The information collected through the community behavior map and the biannual LQAS will inform EIP about unsuccessful BCC approaches. Doer/non-doe analysis methods following BEHAVE training will gather information on the major determinants that determine immunization. Community group sessions facilitated by project staff, local NGO and CBO members will provide an opportunity to discuss and develop tools using appropriate language and methods. This will help generate the mother's booklet that will be a helpful and user-friendly tool on the community level. Children's groups will also promote immunization messages at the community and household to their siblings, peers and mothers in the community.

The matrix below shows the targeted audiences, behaviors, influencing factors and activities proposed

Desired health Outcomes	Target Audience	Behavior to be carried out	Major factors that influence the behavior	Activities that will facilitate the behaviors
To reduce the deaths of children through Failure to Immunize	Caretakers of children under 5 years of age	Caretakers should get their child fully immunized by the 1 st year Caretakers will always maintain an updated vaccination card	Failure to recognize importance of full immunization status, cost for care-seeking, Other factors (to be determined by doer/non-doer analysis)	Individual/ Household: Interpersonal communication Community/ Health Facility: Community Health Information System, Development and use of “New Mother” Booklet, HADs, IMCI Training and supervision District/ Provincial: Strengthen health facility supportive supervision, Avail vaccines and supplies
	Grandmothers and Children	To help prompt caretakers to fully immunize children before their first birthday		
	Other Community Members			
	Health Workers	To effectively screen children for immunization status and offer needed immunizations during that same visit	Lack of Vaccines & Syringes, Lack of training, Not offering Immunizations daily	National/ Policy: Targeted NIDs, Mass Media

b. Quality Assurance

Cameroon has adopted the WHO goal to achieve 80% of full vaccination coverage for all children under five. The strategy to do so combines routine immunization and supplementary activities (or NIDs). The MOH policy provides childhood and maternal immunization free of charge in every health facility and in outreach posts. The policy is clearly articulated in the National Immunization Guidelines.

Other routine EPI activities articulated by the government policy are Surveillance for Acute Flaccid Paralysis, Measles and Neonatal Tetanus. The guidelines clearly present case definitions and standard procedures.

Annual MOH reports indicate that the current reach of outreach activities is poor and this is mainly because of logistic and transportation difficulties at the level of the frontline health staff. Also cited as a difficulty has been effective community participation by community members who can be used as Relays for this outreach activity.

How the EIP will define, measure and improve quality

The EIP program will be implemented at 5 levels. These are the Community Level, Health Area, the Health District, the Provincial Level and the National Level. The EIP has assembled a coordination team which brings stakeholders together and which will sit regularly to analyze program findings and to make recommendations about what needs to be changed. A mechanism is in place to propose changes to scheduled activities on the local level on the strength of the analysis of information at their level.

At every level the coordination team will use consensus to define quality on each key program area. For Immunization the quality standard at the community level may be “that 65% of children are fully immunized before their 1st birthday” during the 2nd year.

Measurement of quality will be made possible in part by the application of biannual monitoring assessments through the LQAS and the MOST tools. The MOST tools have been adapted from the Health Facility Assessment, and will be able to provide quantitative results about IMCI compliance. These assessments will provide biannual information specified by Health Area that the coordination team would be able to reflect about and propose improvements. At the community level, the Community Behavior maps will be used to provide quarterly updates on the behavior profiles of the community, which will inform quality improvement activities. At the district level an aggregation of the LQAS, MOST and Community Behavior maps from all the Health Areas within the district will inform the coordination committee about how the EIP is doing in respect to achieving its quality targets and what needs to be done to make this continue to happen.

Routine health facility services will remain the backbone of immunization services and provide the launch pad for outreach immunization activities. While health worker attitudes and practices at the facility will be addressed to reduce missed opportunities, the project will also liaise with the district health system to strengthen the vaccine supply system.

Technical training and management assistance for quality EPI services will include: maintenance of cold chain, especially during outreach, safe injection techniques and infection control procedures; review of facility immunization tally sheets; analysis and use of data for immunization planning; and correct counseling of mothers on immunization. Monthly Performance Charts (graphs) will be posted in the facilities and will highlight monthly targets versus achievement.

Skills, supplies (including vaccines and syringes) and supervisory support to health worker will be the factors influencing the quality and safety of vaccination.

EIP will clarify to the caregivers that only potent and safe vaccines are administered to the children.

The Project will support the district health teams to supervise and monitor cold chain and quality of services at the health area level.

Current Supervisory System

The current supervisory system is very top down and is weak in articulating decisions at the implementation level without the express blessing from the top. Currently, Health Area supervision by the District Health Team is conducted monthly; the provincial health team conducts district supervision quarterly and the central level supervises the Provincial Health team biannually. However, this system is encumbered with difficulty, making it irregular, due to lack of resources in terms of qualified staff and logistics. Supervision on the community level is weak.

With the EIP in Cameroon, the provincial level will support the 10 member MOST team (mobile ongoing sustainable training) which will conduct quarterly visits to health facilities and maintain IMCI certification for providers who have already undergone the standard 11-day IMCI training. The EIP will also support district health teams in carrying out proper and regular supervisions of both health services and community level activities. This it will do through promoting stakeholder involvement and buy-in in the elaboration of the District Workplan that is done at the end of every year, and by providing logistic support. Supervision shall be a budgeted activity and this will ensure that it is done. The EIP will provide support to the Local NGOs for CBO supervision by factoring compensation of staff time spent on supervision on their sub-agreements. The EIP's monitoring and evaluation plan that allows for stakeholder biannual reflection of the program following the LQAS and IHFA will strengthen the existing supervision system.

At the community level, the project will encourage timely attendance for vaccinations, retention of the vaccination card and presentation during sick child consultation in the health facilities, and early care seeking and reporting of vaccine preventable illnesses

Tools to Promote Quality of Service

The IMCI protocol will form the reference guide to guide the quality of immunization at the facility level. MOST supervision will directly observe health worker practice and caretaker exit interviews to assess whether sick children have been screened for immunization status and whether they have received the required vaccination during that visit. Review of the Immunization Register and Immunization Tally Sheets and will monitor quality of Immunization activities.

Availability of Health Related Products

Cameroon is supported by the Global Alliance for Vaccines and Immunization (GAVI) and UNICEF that ensures provision of potent. Countries eligible for GAVI support are able to secure a constant supply of vaccines and auto-disable syringes for routine immunization programs and these are given free of charge to the children and mothers. It is expected that during the life of the program that this supply will continue. The MOH constantly monitors quality and potency of the vaccines through cold chain surveillance. The MOH also has a policy for injection safety and uses autodisable syringes and incineration after use. The EIP will support districts in the strict application of this policy.

c. Access to services

The fact that the immunization service is offered free of cost will increase access to the population. The EIP will use a community health Information system or community based register, BCC and HADs to identify and encourage non-users to avail of these services. The Government of Cameroon is also planning to reduce geographical access to health Facilities by constructing one thousand new health facilities by 2010.

Equitable Access

The health areas (supervision areas) with the poorest indicators from the baseline survey and the hardest to reach areas will be given priority in the allocation of resources.

5. Program Monitoring and Evaluation Plan:

Description of the current information system

The MOH has put in place a National Health Information Management System (NHIMS) in which Under 5 morbidity and mortality can be captured for Malaria, Tetanus and Diarrhea. Also captured are Immunization for BCG, Polio3, DPT3, Measles and TT2 immunization for pregnant women. Besides this NHIMS, vertical programs like EPI, Malaria Control and AIDS have also developed independent information systems. All these systems have provided tools for entry by health facility personnel on a monthly basis (or weekly basis for those illnesses under surveillance). A software exists to process the NHIMS data but is only operational at the level of the province since most of the Health Districts are newly equipped with computers and their personnel have not been trained to operate the software program. In general all the various forms filled at health facility level are sent to the district and provincial level without local level analysis and exploitation.

At the community level, there is no formal health information system. Immunization and growth monitoring registers are found in some Plan assisted communities where CBOs or Health Area Committee members have been exposed to C-IMCI. Again there is no formal system to process and analyze the information contained in those registers.

From the experiences of Plan, PSI/ACMS and HKI in monitoring and evaluation within projects implemented in Cameroon and elsewhere, the partners know that the EIP must have a simple, cost-effective, and useful monitoring systems to achieve sustainability. Moreover, monitoring and evaluation efforts will be sustainable only if local stakeholders are aware of the value of collecting data to inform their work. Therefore, the EIP will use an evaluation and monitoring system that will be:

- Participatory so that collected information will be used by several stakeholders to promote discussion on better ways of taking action to improve the health of the community.
- Simple to apply, with field-tested methods that are easy to use and of low cost to replicate after the conclusion of the project.
- Conducive to decision making, by fostering participatory discussion and accessible presentation and analysis of the information so that partners can make better decisions on resource allocation and programming.
- Complementary to the existing HIS of the MOH, so that the information collected by the EIP will complement the epidemiological and health production information regularly collected by MOH health facilities.

The EIP will work with all levels of stakeholders and implementers in collecting the health information to enable improved analysis and decision-making. While a facility health information system will be capturing immunization of children and pregnant women, morbidity and mortality aspects towards the target illnesses and quality of care, a community health information system will be capturing the progress in behaviors and adherence to positive practices at the community level.

Results-Based Objectives

Objective/ Result	Indicators (by technical intervention or cross-cutting)	Source/ Measurement Method	Frequency	Baseline Value	EOP Target
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MALARIA						
At least 65% of frontline MOH and private providers apply the case management protocols for suspected malaria cases and the administration of IPT	% of frontline MOH and private providers apply the case management protocols for suspected malaria cases and the administration of IPT	MOST reports, IHFA	Quarter, Semi-annual	No baseline	65%	
Increase from 11.8% to 60% children age 0-23 months who slept under an ITN the previous night	% of children age 0-23 months who slept under an insecticide-treated net the previous night.	KPC/LQAS	Semi-annual	11.8%	60%	
Increase from 15.7% to 60% pregnant women who slept under an ITN the previous night.	% of pregnant women who slept under an insecticide-treated net the previous night.	KPC/LQAS	Semi-annual	15.7%	60%	
Increase from 11.7% 60% children age 0-59 months who received a full course of recommended anti-malarial within the 24 hours of onset of fever	% of children age 0-59 months who received a full-course of recommended anti-malarial (according to the MOH's recently approved home-management protocols) within the 24 hours of the onset of fever	KPC/LQAS	Semi-annual	11.7%	60%	
Increase from 2.8% to 75% women who completed IPT during their current or last pregnancy	% of women who completed Intermittent Presumptive Treatment (IPT) during their current or last pregnancy.	KPC/LQAS	Semi-annual	2.8%	75%	
Increase from by 25% the number of net owners who have retreated net at least once in the last year	% of net owners who have retreated net at least once in the last year	Community mapping, KPC/LQAS	Monthly, Semi-annual	No baseline	25% increase over baseline	
NUTRITION						
At least 80% of front-line MOH and private providers administer vitamin A supplements to children 6-59 months and women within 8 weeks post partum according to the MOH standards.	% of front-line MOH and private providers administer vitamin A supplements to children 6-59 months according to the MOH standards.	MOST reports, IHFA	Quarter, Semi-annual	No baseline	80%	
	% of front-line MOH and private providers administer vitamin A supplements to women within 8 weeks post partum according to the MOH standards.	MOST reports, IHFA	Quarter, Semi-annual	No baseline	80%	
Decrease from 15.9% to 10 % children age 0-23 months who are under-weight (-2 SD from the median weight-for-age,	% of children age 0-23 months who are under-weight (-2 SD from the median weight-for-age, according to the	KPC/LQAS	Semi-annual	15.9%	10%	

according to the WHO/NCHS reference population).	WHO/NCHS reference population).				
Increase from 50.8% to 75.8% children age 0-5 months who were exclusively breast-feeding during the last 24 hours.	% of children age 0-5 months who were exclusively breast-feeding during the last 24 hours	KPC/LQ AS	Semi-annual	50.8%	75.8%
Increase from 92.1% to 95% children age 6-9 months who received breast-milk and complementary foods during the last 24 hours.	% of children age 6-9 months who received breast-milk and complementary foods during the last 24 hours	KPC/LQ AS	Semi-annual	92.1%	95%
Increase from 65.3% to 80% children age 6-9 months who received animal and/or vegetable protein during the last 24 hours	% of children age 6-9 months who received animal and/or vegetable protein during the last 24 hours	KPC/LQ AS	Semi-annual	65.3%	80%
Increase to 90% children age 6-59 months who received vitamin A supplementation in the prior 6 months.	% of children age 6-59 months who received a Vitamin A supplement in the prior 6 months	KPC/LQ AS	Semi-annual	80.9%	90%
Increase to 80% mothers giving birth in the last 12 months who received two vitamin A supplements within 8 weeks post partum.	% of mothers of children age 0-32 who received two Vitamin A supplements within 8 weeks post partum	KPC/LQ AS	Semi-annual	21.6%	80%
Increase from 9.2% to 40% sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	KPC/LQ AS	Semi-annual	9.2%	40%
The National IMCI and Nutrition Working Groups support the MOH in the drafting of at least two public policies or protocols related to the scale-up of IMCI/RBM in the country.	Number of public policies or protocols related to the scale-up of IMCI/RBM in the country.	EIP Annual report	Annual		At least two policies
Increase in 30% points (from baseline) of pregnant women taking IFA supplements daily for at least 6 months during their last pregnancy.	% of mothers of children age 0-32 taking iron/folate supplements daily for at least 5 months during their last pregnancy	KPC/LQ AS	Semi-annual	27.2%	60%
Increase in 25% points (from baseline) of children 6-59 months of age eating vitamin A rich foods daily during the past	% of children 6-59 months of age eating vitamin A rich foods daily during the past	KPC/LQ AS	Semi-annual	41.3%	60%

rich foods daily during the past week.	week.				
DIARRHEA					
Increase from 7.7% to 30% mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.	% of mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.	KPC/LQ AS	Semi-annual	7.7%	30%
Increase from 9.2% to 40% sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	KPC/LQ AS	Semi-annual	9.2%	40%
At least 60% of front line MOH providers and private providers administer zinc supplements to under-five children for treatment (and prevention) of severe diarrhea cases (if approved by MOH).	% of front line MOH providers and private providers administer zinc supplements to under-five children for treatment (and prevention) of severe diarrhea cases (if approved by MOH).	MOST reports, IHFA	Quarter, Semi-annual	No baseline	60%
PNEUMONIA					
Increase from 65.9% to 80% mothers of children age 0-23 months who know at least 2 signs of childhood illness (fast breathing and chest in-drawing) that indicate the need for treatment.	% of mothers of children age 0-23 months who know at least two signs of childhood illness (fast breathing and chest in-drawing) that indicate the need for treatment.	KPC/LQ AS	Semi-annual	65.9%	80%
Increase from 37.4% to 67.7% children with signs of severe childhood illness who were seen by a qualified public or private provider in the past 2 weeks.	% of children with signs of severe childhood illness who were seen by a qualified public or private provider in the past two weeks.	KPC/LQ AS	Semi-annual	37.4%	67.7%
Increase from 11.2% to 65% of front-line MOH and private providers manage sick children according to the MOH's IMCI protocol.	% of front-line MOH and private providers manage sick children according to the MOH's IMCI protocol.			11.2%	65%
Increase from 9.2% to 40% sick	% of sick children age 0-23	KPC/LQ	Semi-	9.2%	40%

children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	months who received increased fluids and continued feeding during an illness in the past two weeks.	AS	annual		
IMMUNIZATION					
Increase from 70.5% to 80% children age 0-23 months who received vaccination coverage for all the antigens (Tuberculosis, Diphtheria, Measles, Tetanus, Pertussis, Poliomyelitis, Hepatitis B and Yellow Fever)	% of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	KPC/LQ AS	Semi-annual	70.5%	80%
Increase from 58.9% to 80% mothers of children age 0-23 months who received 2TT during their last pregnancy	% of mothers of children age 0-23 months who received 2TT during their last pregnancy	KPC/LQ AS	Semi-annual	58.9%	80%

INTEGRATED MANAGEMENT OF CHILD ILLNESS

Objective/ Result	Indicators (by technical intervention or cross-cutting)	Source/ Measurement Method	Frequency	Baseline Value	EOP Target
Increase from 65.9% to 80% of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment	% of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment.	KPC/LQ AS	Semi-annual	65.9%	80%
Increase from 37.4% to 67.7% of children with signs of severe childhood illness who were seen by a qualified public or private provider in the past two weeks.	% of children with signs of severe childhood illness who were seen by a qualified public or private provider in the past two weeks.	KPC/LQ AS	Semi-annual	37.7%	67.7%
Increase from 9.2% to 40% of sick children age 0-23 months that received increased fluids and continued feeding during an illness in the past two weeks.	% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	KPC/LQ AS	Semi-annual	9.2%	40%
To increase from 11.2 to 65% front-line MOH and private providers manage sick children according to the MOH's IMCI protocol.	Percentage of front-line MOH providers who manage sick children according to the MOH's IMCI protocol.	MOST reports, IHFA	Quarter, Semi-annual	11.2%	65%

CAPACITY BUILDING

At the district, community and local levels

Objective/ Result	Indicators (by technical intervention or cross-cutting)	Source/ Measurement Method	Frequency	Baseline Value	EOP Target
80% of District Coordination Meetings, in 8 of the 11 districts, meet monthly and bring together all district stakeholder	Percentage of District Coordination Meetings monthly and bringing together district stakeholders	EIP Annual Report	Annual	No baseline	80%
90% of women-based CBO's will be designing and implementing health promotion and prevention activities in the prior three months.	Percentage of women-based CBO's designing and implementing health promotion and prevention activities in the prior three months	District/ LNGO quarterly report	Quarter	No baseline	90%
90% of COSA/COGE will be applying their business plans to improve the management of health problems in their Health Area.	Percentage of COSA/COGE applying their business plans to improve the management of health problems in their Health Area.	District quarterly report	Quarter	No baseline	90%
90% of MOH Health Districts will provide supervision and technical support to the IHC and peripheral facilities on IMCI, RBM or nutrition at least once in the last three months.	Percentage of MOH Health Districts that have provided supervision and technical support to the IHC and peripheral facilities on IMCI, RBM or nutrition at least once in the last three months	District quarterly report	Quarter	No baseline	90%

At the national level

Objective/ Result	Indicators (by technical intervention or cross-cutting)	Source/ Measurement Method	Frequency	Baseline Value	EOP Target
The National IMCI and Nutrition Working Groups support the MOH in the drafting of at least two public policies or protocols related to the scale-up of IMCI/RBM in the country.	Number of public policies or protocols drafted.	EIP Annual report	Annual		At least two Policies
The National IMCI and Nutrition Working Groups support the MOH in the preparation of project proposals for the scale-up of IMCI/RBM and Nutrition in the country through domestic (e.g. HIPC initiative) and foreign (World Bank, EU, Bilateral Cooperation, Global Fund)	Number of project proposals for the scale-up of IMCI/RBM and Nutrition in the country through domestic (e.g. HIPC initiative) and foreign (World Bank, EU, Bilateral	EIP Annual report	Annual		

development assistance.	Cooperation, Global Fund) development assistance.				
Within Plan Cameroon, ACMS and HKI's development and capacity-building programming key health behaviors to prevent and treat malaria, pneumonia, diarrhea and malnutrition are promoted to children, family members and communities participating in the partners' development and capacity building programs, especially water and sanitation, primary education, CDTI, social marketing activities, promotion of children's participation, HACI (Hope for African Children Initiative on HIV/AIDS prevention) and micro-credit for women groups.	Number of development and capacity building programs in Plan Cameroon, ACMS and HKI that have incorporated the promotion of key health behaviors to prevent and treat malaria, pneumonia, diarrhea and malnutrition to children, family members and community groups.	EIP Annual report	Annual		At least three Behaviors
Within Plan, PSI and HKI's development and capacity-building programs in West Africa: The processes and lessons learnt on integration and scaling-up of the EIP have been disseminated and analyzed in at least six Plan, PSI or HKI country programs in West Africa for their potential replication.	Number of Plan, PSI and HKI country programs in West Africa that have discussed the processes and lessons learnt on integration and scaling-up of the EIP for their potential replication.	ACMS, HKI and Plan West Africa annual report	Annual		6 countries

EIP Indicators to measure sustained health outcomes

Complementary to the above result-based objectives the Project shall track the following sustainability assessment Indicators defined during the CSSA Workshop.

COMPONENT 1

Rapid CATCH: Source LQAS

1. % of children who are underweight
2. % of children born at least 24 months after their immediate surviving elder
3. % mothers who received at least 2 TT shots before birth of youngest child
4. % children whose birth was attended by skilled personnel
5. % children 0-5 months exclusively breastfed
6. % children 6-9 months who received breastmilk and complementary feeds within the last 24 hours
7. % children 12-23 months fully vaccinated
8. % children 12-23 months who have received measles vaccination

9. % children who slept under ITN the previous night
10. % mothers who know two signs of childhood illness indicating need for treatment
11. % sick children who received increased fluids and continued feeding during illness
12. % mother who cite 2 ways of reducing HIV infection risk
13. % mothers who wash their hands with soap before food preparation, before child feeding, after defecation and after attending a child who has defecated

COMPONENT 2

Health Service Index: Source IHFA (for No. 2 to 5) and LQAS (for No. 1)

1. % of children with signs of severe childhood illness who were seen by qualified provider in past 2 weeks (ACCESS)
2. % of children who were assessed for all danger signs (SCREENING)
3. % of children whose weight was plotted on a growth chart (CLINICAL EXAMINATION)
4. % of children who received an appropriate medication for the diagnosis made by the health worker (TREATMENT)
5. % of health workers who saw children and who had received IMCI training in the last 12 months (TRAINING)

COMPONENT 3

OCAT Capacity Index: Source OCAT

1. Planning: Are activities planned and decisions made in line with the strategies that have been identified for achieving the missions of the NGO?
2. Administrative Procedures: What are the procedures for recording, filing, purchasing and intra office communication?
3. Information System: How is the collection, analysis and dissemination of information organized in the organization?
4. Program/Beneficiary sustainability: Are there NGO programs for which the community eventually assumed management responsibility?
5. Financial reporting: Have funders ever complained about either the insufficiency or the tardiness of financial reports?

COMPONENT 4

OCAT Viability Index: Source OCAT

1. Stakeholders: Does the NGO undertake periodic surveys of its community to find out if they are satisfied with services or activities?
2. Financial reporting: how well is the organization performing in terms of financial analysis/cost effectiveness?
3. Inter-NGO Collaboration: Does the NGO maintain national or international linkages with other NGOs?
4. Marketing and Awareness Building: How does the NGO raise awareness of its activities among its stakeholders?
5. Resource Base Sustainability: Is there a long-term business/funding/resource development plan for the needed financial resources

COMPONENT 5

Malaria Competence Index: Source (CSAT) Competence Self Assessment Tool

- | | |
|--------------------------------|------------------------------------|
| 1. Facts of life | 8. Prevention IPT |
| 2. Acknowledgement | 9. Gender Driven Response |
| 3. Inclusion of the Vulnerable | 10. Learning and Transfer |
| 4. Access to treatment | 11. Measuring Change |
| 5. Severe Malaria | 12. Adapting our Response |
| 6. Prevention ITN | 13. Ways of Deploying our Strength |
| 7. Prevention IRS | 14. Mobilizing Resources |

COMPONENT 6

Source: Country level Statistics

1. % Women Literacy
2. Degree of Political Interference in local Programs
3. % of population housed in electrified homes
4. MOH ability to recruit new staff and minimize health personnel transfers

Data Collection

The MOH will continue collecting information on a monthly basis on its health facility-based and community-based activities, such as the number of children immunized, number of sick children attending the health facilities and number of home visits done by IHC staff. The EIP will support the collection of data for compliance to key family health behaviors, such as exclusive breast-feeding and hand washing with soap, through the use of the CBO behavior maps and the bi-annual LQAS. Moreover, the EIP will support the MOH in the bi-annual implementation of the IHFA, which will assess the performance of the facility-based health workers in key case management behaviors and quality of care. At the community level, the community behavior map will be produced on a monthly basis. The district level, in addition to the consolidated activity report form currently in use, will have community and Health Area level data added. Mystery client visit reports from private health facilities and Sales Reports of health products by commercial outlets will also be collected quarterly. EIP Program inputs and outputs and financial information will be obtained from Plan's PPM (Programs and Projects Module) at the provincial level.

Data Quality

The district health teams, the IHC chief and the provincial M&E focal persons have already been trained in the use of the LQAS methodology for KPC and IHFA tools. Building on these initial trainings, refresher courses will be organized and a course in Epi Info will be given to the district medical teams so that the collected data can be managed and used at the local level.

Description of Monitoring Tools

The program will use a variety of tools for monitoring EIP's progress. These include the community behavior map, the community based register, an integrated facility based data collection tool (called the MOST tool), a mystery client visit tool for use at private health

facilities, a sales register for consolidating sales information of health products at commercial outlets, Integrated Health Facility Assessment (IHFA) tool, Lot Quality Assurance Sampling (LQAS) modules and Plan PPM software.

The community behavior map is a community map in which a colored thumbtack is placed besides each household to show the compliance or non-compliance with the desired behavior.

Project wide LQAS will provide quantitative data on the various key EIP indicators and all RAPID CATCH indicators. The methodology subdivides a health district into supervision areas where 19 randomly selected households are interviewed. The supervision area will be the Health Area. It will ask questions based on the KPC 2000+ RAPID CATCH questionnaire for its first 4 modules: Mothers of children age 0-23 months, Mothers of children age 0-5 months, Mothers of children age 6-9 months, Mothers of children age and 12-23 months. The fifth module will assess Mothers of children age 6-59 months who consumed food rich in Vitamin A in the week preceding the survey. LQAS will permit the project to assess coverage estimates and tell which Supervision Areas are below the program coverage rate for particular indicators and thus need more help. An innovation about this LQAS is that it will be done as part of project staff routine work.

IHFA will be applied at the Health Districts. The Integrated Health Facility Assessment is designed to measure the core elements of integrated case-management practices and the facility-supports required or these practices.

The facility based MOST collection tool is a tool which integrates the various reporting requirements that exist at the health facility. This tool is still being refined by the EIP and MOH.

The Mystery Client tool is an exit interview questionnaire that is tailored to elicit case management proficiency of a private health worker from a client that they have seen. It reduces the influence due to the presence of a case management observer in the consultation room. It assesses compliance with the IMCI case management steps of screening, assessment, classification, treatment and counseling.

The Sales Register will detail the monthly sales of essential health products (ITNs, treatment kits for ITNs, ORS, and home chlorination kits) through various commercial outlets. The ACMS provincial health products promoter will prepare a health products sales report on a monthly basis.

PPM is Plan's corporate Programs and Projects modules whose prime use is to monitor project input and output and beneficiaries reached.

The Project sources of Data

The sources of data can be divided into three groups:

- Community based data collected in the community from households and individuals,
- Facility based data those collected at the health facility

- Output delivery and financial data from Plan CPME (Corporate Planning Monitoring and Evaluation) system.

Community based information

Different data collection tools will be employed by the project in the data collection process. All activities will focus on building the capacity of local community members or medical personnel to continue health monitoring at the end of the project.

At community level

1. The Community based child register will collect information on all births entered by month, immunization status and vitamin A supplementation status of each child below 2 years of age, de-worming status, weight for age, child ITN possession and use, and OVC data. Deaths of children will also be collected including those deaths of newborns that haven't been named as yet. The community register will be the community based HIS source of information where the health facility outreach immunization activities, the community behavior map results, the CBO growth monitoring activities and PD/HEARTH activities will be documented monthly.
2. The Community Behavior Map will collect information on a monthly basis on the practice of a limited number of easily observable household health behaviors. Examples of these behaviors are ITN use, hand washing practices, existence of exclusive breast-feeding in children aged less than 6 months, existence of solid feeding in children older than 6 months, compliance with IPT and vitamin A or IFA supplementation, children with fever that are receiving appropriate anti-malarial treatment, children with pneumonia promptly referred for care from appropriate providers, children with diarrhea that are receiving ORT, and immunization status in children aged less than one year. A local NGO staff will facilitate the process.
3. At the community level, CBO members will periodically reevaluate targets set for malaria community competence and revise annual targets in competency 14 areas using the Community Self Assessment Tool.
4. PD/HEARTH report in eligible communities will report the progress made by the client of the nutrition rehabilitation activities in the communities.
5. LQAS will be conducted semi annually. MOH, Local NGO, and EIP staffs will set aside a day to visit each of the 19 villages randomly sampled in each Supervision area. The EIP area has an updated census list that gives the population denominators. The surveyors will fill out one set of questionnaires during this day as they also do other program work in the village. Nineteen sets of questionnaires will be filled over a period of one month.
6. The ACMS provincial health products promoter will prepare a health products sales summary report on a monthly basis. This report will be consolidated by the ACMS central information system to generate country wide report.

Facility based data

1. The Head of the IHC will fill an activity report form on a monthly basis on their facility- and community-based activities, such as the number of children immunized, number of sick children attending the health facilities, number of home visits and outreach sessions done by IHC staff.
2. The MOST tool which is an adaptation of the IHFA tool but which also integrates other quality service indicators, will be used to measure child service quality by the MOST team. The tools will have a case management observation section and a caretaker exit interview section adapted from the IMCI package. It will be applied quarterly.
3. Mystery client visit reports from private health centers will be consolidated quarterly at the district level, and the outcome discussed during the health district quarterly meeting.
4. IHFA will be used to measure the achievement of the public and private facility-based behaviors.

Plan Data

The Plan PPM will produce quarterly reports of what inputs have been provided by the EIP and what outputs have been achieved.

Data Analysis and Dissemination

The table below shows how data shall be analyzed and disseminated within the EIP.

Table: Flow of information and decision making in the EIP		
Setting	Information Collected	Decision Making
Village (1543)	CBO behavior maps	CBO members agree on activities to increase compliance of CBO members to healthy behaviors
Health Area (106)	1. Health Area's production and coverage information, including patient referral and counter-referral; 2. Aggregate of CBO behavior maps	During quarterly meetings, Health Area's stakeholders plan and allocate resources for community health activities in the villages.
Health Districts (11)	(1) Report on LQAS and IHFA. (2) Aggregate of Health Areas' production and coverage information and Health District's production and coverage information. (3) Aggregate of CBO behavior maps. (4) Patient Referral and counter-referral (5) Report on sales of health products by commercial outlets. (6) Reports of mystery clients (7) Reports of MOST teams	During bi-annual meetings, Health District's stakeholders make a Plan of Action to improve health conditions in the District.

Provincial Health Delegation	Aggregate of the Districts' information plus production and coverage information of the Provincial Health Delegation and output and financial information from Plan's PPM.	During bi-annual meetings, Provincial stakeholders agree on a Plan of Action to support the Health Districts' Plans.
EIP Provincial Planning Committee	Aggregate and province-level information.	During bi-annual meetings, EIP stakeholders agree on a Plan of Action to support the Health Districts' and Provinces' Plans.
Project Coordination Committee.	Aggregates and consolidates data from the three provinces	During bi-annual meetings, EIP Core Partners agree on a Plan of Action to support the MOH.

Data will be analyzed and results sharing forums held at the community, health area, health district, province and country levels to monitor program progress and improve program process and program performance.

After the CBO Behavior Map is finalized, the staff of the local NGO will act as a resource person for a group discussion on ways to improve the compliance with the desired behaviors. Compliers can share their experiences about how they adopted the behavior, such as children sleeping under a bed net, while non-compliers can talk about the barriers they currently face. CBO members will continue sharing ideas on the best ways to increase positive health practices. The staff of the local NGO will attend the meeting but only to participate as a resource person in the discussion. After the majority of the CBO members have adopted a specific behavior, another behavior will be included for CBO monitoring.

The IHC chief and a local NGO staff will facilitate the quarterly meetings at health area level. This meeting will bring together all CHRPs, two representatives of each of the CBOs in a Health Area, IHC staff and representatives of the COSA and COGE. The EIP Provincial Health Coordinator and the capacity building supervisor will attend this meeting as well. During this meeting, the CBO leaders will present their CBO Behavior Maps, compare their current practices with other CBOs and exchange ideas on how to accelerate the adoption of healthy behaviors. Finally, IHC staff, COSA/COGE representatives and CBO leaders will agree on the planning of specific community health activities in the villages where these CBOs are located. At the end of the meeting, the head of the IHC and the staff of the local NGO will fill out a summary report with the aggregated information of the CBO Behavior Maps. This information will be sent to the Health District authorities. At the Health Facility the IHC chief will draw a Monthly Performance Chart for Immunization and display it in an open place in the facility for all people to see.

The Health District authorities will use six pieces of information for decision making and resource allocation: The information regularly collected by the Health Areas and the District Hospital on health production and coverage; The quarterly reports on the CBO Behavior Maps at each Health Area, Mystery Client visits reports from private health facilities, Report of the MOST teams; Results of LQAS and IHFA in each Health District and Sales summary of essential health supplies by private vendors.

Since all the health districts are equipped with computers, the program will reinforce capacity of health district and EIP staffs in the use of EPI-Info software to allow local data processing and analysis.

Ongoing Assessments

LQAS and IHFA will be conducted biannually. LQAS will assess household behaviors key in achieving the EIP objectives. IHFA will be used to measure the achievement of the public and private facility-based case management behaviors. District stakeholders will discuss these results and make program recommendations to improve the current situation. During the bi-annual meeting of the Provincial Implementation Committee of the EIP the results of the district-based LQAS and IHFA plus the list of recommendations from the meetings of the district stakeholders will be presented and discussed. A Province-based Plan of Action will be prepared to support the recommendations of the districts' stakeholders. Provincial stakeholders will agree on a Plan of Action to support the Health Districts' Plans to improve health condition in the district.

In addition to the semester based IHFA, a more frequent assessment of selected IHFA indicators will be done by the MOST team on a quarterly basis. The MOST reports and the Mystery clients visits to health centers reports will be discussed during the District quarterly meeting and the agreed recommendations factored within the District Plan of Action.

Responsibility for Project M & E System

Four members of the project team will have substantial involvement in the management of health information. These staff will include the HIS Assistant at the Central Office based in Yaoundé and three Monitoring and Evaluation Supervisors based in the three Provincial EIP Teams. Apart from managing the information generated by the EIP and its partners, this group will provide technical M & E support and supervision to the CBOs, local NGOs and district-based stakeholders in the satisfactory implementation of the CBO Behavior Maps and the IHFA/LQAS.

Assessment and strengthening M & E Skills of local staff

The OCA tool and supervision checklists will be used to assess M&E skills of CBOs and local NGOs. The semester based IHFA will also include a section to assess Health Area committees and Health staffs M&E skills.

Effort will be made to reinforce the capacity of all the partners in the use of the monitoring and evaluation methodologies tools within EIP. Local NGOs and District staffs' capacities will be reinforced on KPC/LQAS, and facilitation of Community mapping. Provincial MOH will horn skills in the conduct of Health Facility Assessment and IMCI supervision.

Sustainability of Community M & E System

After the initial facilitation of the community mapping process by the LNGO staff, the community will gradually be able to conduct the process alone and make decisions. The ownership of the process by the community will be sustained as the community members will master the whole process and apply it to other development programs.

Operational Research

The EIP, through HKI, will conduct operations research (OR) on the administration of Zinc supplements during and after a diarrhea episode. The Question for the OR study will be: “What is the efficacy of Zinc in the treatment and prevention of diarrhea in U5s in Cameroon? What are the determinants of accessibility, utilization and compliance to Zinc therapy?”

In addition to this the program will support small-scale operations research on topics such as the use of low osmolarity ORS for Diarrhea Management.

The EIP will financially support the two themes that receive the highest priority from the IMCI and the Nutrition National Working Groups with grants of up to \$20,000 USD each. Implementers may include one of the PVO partners, one of the eleven local NGOs or another suitable partner such as the local university.

CSHGP Program Results that this project will contribute to

Linked Strategies and Goals			
CSHGP	EIP Activities	Sample EIP Objectives	Data Sources
PR1: Improve Health Status of Vulnerable Target Populations.	Will improve facility-based and community-based IMCI/RBM through the combined effort of communities, private and public institutions in 3 provinces; benefits 1999,721 under five children and 454,687 women of reproductive age.	Increase from 11.8% to 50% children age 0-23 months who slept under an ITN the previous night	Semi-annual LQAS
PR2: Increased Scale of Health Interventions.	Promotes lasting behavior change through households, strengthens community-level human resources, involves commercial sector, addresses nutritional component of IMCI/RBM and encourages MOH and private facility response to IMCI/RBM. Integrated into partner development and capacity building programs to facilitate institutional sustainability. Develops community-based model that prevents childhood illness and treats illness through links with the health sector. Supports the District Health Workplan, Work with local and international NGOs, for-profit and non-profit health providers and the commercial sector	80% of the District Coordination Meetings in 8 Districts meet monthly and bring together all relevant stakeholders	Annual EIP Report
PR3: Increased contribution of CSHGP to the global capacity and leadership	Preparation of relevant policies and investment plans, strengthens national networks on IMCI. Work with local and international NGOs, for-profit and non-profit health providers and the commercial	The National IMCI and Nutrition Working Groups support the MOH in the drafting of at least two public policies or	Annual EIP Report

for Child Survival and Health.	<p>sector</p> <p>Provides methods and lessons learned related to national scale-up of IMCI/RBM, strengthens nutrition component of IMCI/RBM at community and health facility levels, and integration within development programming, which has broad application to larger development community. Documents and shares the practice of LQAS and the MOST strategy.</p>	<p>protocols related to the scale-up of IMCI/RBM in the country</p>	
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Evaluation Plan

Mid-Term (MTE) and Final Evaluations (FE) will be executed during the third and fifth year of the project, respectively. A team of project stakeholders led by an external consultant will implement both. Representatives of the PVO Headquarters and USAID WARP will also participate. Apart from the data collected regularly in CBO Behavior Maps and bi-yearly IHFA/LQAS, the baseline assessment studies will be repeated. This will include focus groups, IHFA among private health providers and the status of the distribution of essential health commodities through commercial outlets. These studies will be completed with key informant interviews and visits of ACMS “mystery clients” to health facilities and commercial outlets.

The results of the MTE and FE will be disseminated and published within the National IMCI Working Group. Summaries of the findings may also feature in the IMCI Technical Update.

6. Program Management

The EIP has assigned management responsibilities at four levels: the health district, provincial level, national level and at the US headquarters of the partner PVOs. The proposed program allows for decision-making close to the implementation level, capacity building for provincial and national level partners, and adequate financial oversight and coordination at the national and United States level. As prime partner, Plan will retain fiduciary responsibility of the program, and therefore Plan staff will serve as the organizing force at each management level as shown below.

Summary of Regularly Scheduled Meetings Among Partners	
Level	Meeting and Attendees
District	Monthly Implementation Meeting: Plan, ACMS, HKI and local implementing NGO, COSA, COGE and CBO members
Province	Quarterly Provincial Implementation Committee Meeting: Provincial Health Delegate, District Medical Officers, Provincial Health Coordinator, Capacity Building Supervisor, M&E Supervisor, representatives of HKI, ACMS, and the local implementing NGO, private health facility staff, COSA, COGE and CBO members
National	Semi-annual EIP Planning Committee: Plan, ACMS and HKI Country Representatives, MOH
US	Semi-annual Partner Meeting: Technical US-based backstops for Plan, PSI and HKI in person, EIP Planning Committee by phone

In the 11 Program Districts: Within the participating districts, Plan and HKI will implement strengthening activities with the MOH. ACMS will strengthen the distribution of essential health commodities through the private sector, and will design and carry out the mass media communications activities.

The local NGOs will conduct community mobilization, training and health promotion at the district level in each province. They will be monitored by Plan Cameroon through their sub-grant agreements. Each proposed NGO has recent, successful working experience with Plan in similar health projects like the HACI project, the NLNO C-IMCI project and the French NO ITN project. The local NGOs will deploy a Field Supervisor and 2-3 Field Promoters in each health district. Plan, ACMS and HKI representatives, represented within the EIP project, will hold meetings with staff of the implementing NGO in their district once each month to share information on successes and difficulties encountered in the project, and to solicit feedback from the local NGO staff. These meetings will help the US PVO partners build the capacity of the local NGOs, while also allowing for regular interaction and joint decision-making between partners.

The local NGO staff will be trained by the PVO partners and will be supervised by the Provincial level Capacity Building Supervisors, described below.

At the Health District Level, the Monthly Implementation Meeting (MIM) shall follow the Coordination Committee meeting that is usually convened by the DMO and that brings together IHC chiefs and other district stakeholders every month. This will provide a forum to discuss and reflect on health information at this level and prioritize programming at the district level. It will include the active participation of the local NGOs.

At the 3 participating provinces (Center, East and Northwest) each member of the Provincial EIP Team will oversee the project's activities in the Health Districts. Among other functions, team members will meet regularly with the Health District and Health Area authorities, CBOs, COSAs,

COGEs and the staff of the implementing local NGOs. The Provincial EIP Team will also participate in the district coordination meetings and semi-annual monitoring of family behaviors (LQAS) and health facilities (IHFA) described in Chapter 4, Program Monitoring and Evaluation Plan. For this event, the EIP will promote a Task Force comprising project personnel, local NGOs, COSA/COGE and MOH staff that will plan and implement the monitoring, process the results and lead the discussion on the analysis and future decision-making.

The Provincial EIP Team will include a Provincial Health Coordinator at a 65% LOE to lead the team, facilitate inter-institutional coordination and cooperation in the province, work with HKI, ACMS, the MOH authorities, local NGOs and associations, private sector companies, international cooperation agencies and local governments involved in the project. The balance of the Provincial Health Coordinator's time will be spent coordinating complementary Plan health programming, ensuring integration of the programs and providing a cost savings to this project. The Capacity Building Supervisor is a full-time position designed to providing supervision and support to the community mobilization and health promotion activities in the provinces, and to the local NGO sub-grantees. The Monitoring and Evaluation Supervisor (MES) at the provincial level is a full-time MOH employee. The MES is responsible for implementing the monitoring and evaluation of the EIP, and implementing the MOH strengthening activities in the province. A Program/Accounting Assistant and a Driver also support each Provincial EIP Team. The day-to-day supervision and administrative support of the Provincial EIP Team will rely on the Manager of each Plan Provincial Office. This management arrangement will assure integration of the EIP's activities within Plan Cameroon's development programming in the provinces.

In each of the three participating provinces, the Provincial EIP Team will organize a **Provincial Implementation Committee (PIC)** to gather the input of local stakeholders. The committee will coordinate, plan and monitor the local progress of the EIP. The PIC will meet four times a year, immediately after the regular meetings of the MOH's Provincial and District Medical Officers, and will comprise: the Provincial Health Delegate; the District Medical Officers participating in the EIP, the Provincial EIP Team; the representatives of HKI and ACMS working in the province; the local NGO implementing the EIP's community mobilization activities in the province; and other public and private institutions relevant to the EIP's progress in the province, such as missionary hospitals.

At the national level (based in Yaoundé): Plan will work collaboratively with HKI, ACMS and MOH for the achievement of EIP objectives. An EIP Planning Committee (EPC) will include the representatives of these three institutions in Cameroon and the MOH to accomplish standard program planning and oversight activities and will meet every 6 months. The EIP Planning Committee (EPC) will convene at the level of the Division of Family Health. It will bring together Plan, ACMS, HKI, Head of Malaria Control Program and the Director of Family Health. The EPC will draft and agree on annual work-plans and budgets, and will complete annual reports to USAID. For the Mid-Term and Final evaluations, the group will provide advice on and approval of the external consultants' scope of work and progress. After each bi-yearly monitoring activity, the EPC will review the progress made and propose modifications to the annual work-plan.

Each PVO partner has nominated a qualified and experienced representative for the EPC to provide direction and oversight to the project.

EIP Coordinator (full-time, key position). The coordinator will: lead the EIP under the supervision of Plan Cameroon's Country Director; foster links between the program partners; maintain communication with USAID, WARP and contractors; conduct documentation, dissemination and advocacy activities; provide technical assistance to the MOH and the National IMCI Working Group for policy making and scale-up; supervise the three EIP Provincial Teams; and, at the national level, seek to integrate the project within partners' development programming.

Health Information Assistant (HIA). The HIA is responsible for: the design and implementation of the EIP's monitoring and evaluation plan; liaising with the University of Yaoundé; providing program support to the EIP Coordinator; and assisting the Provincial EIP Teams.

Provincial Health Coordinator (PHC)

This position is responsible for

- Overall management of the CS project in the province. This includes EIP staff supervision and public relations.
- Leads the EIP team and Local NGOs in the planning, implementation, and routine monitoring of all the project interventions.
- Writes monthly and quarterly progress reports of the project.
- Organizes monthly meetings within the Province and with other PVO representative (HKI & ACMS) and Local NGOs
- In collaboration with the capacity building supervisor, develops training programs for Local NGOs, CBOs, community health teams and health workers involved in the project.
- Leads all investigation, surveys and research operations associated with the project at provincial level.
- Leads semi-annual monitoring of family behaviors and health facilities in each Health district within the province.
- Coordinates complementary Plan health programming, ensuring integration of the programs

Capacity Building Supervisors (CBS)

This position is responsible for

- Assisting the PHC
- Provides support to DHMTs, LNGOs, COGEs, COSAs, CBOs and CHRPs in training, supervision and monitoring.
- Trains and Supervises health promoters and CBOs.
- Provide support for all health coordination meeting at all levels (Community, Health Area, District, and Provincial level)

M&E Supervisor based at provincial delegation:

This position is responsible for

- Implementation and strengthening of the MOH HIS activities in the province
- Train District MOH staff in HIS related software and compiling of reports
- Manages data entry and analysis following semi-annual LQAS and IHFA.
- Provides Support to DHMT during coordination meetings

Staff based at the ACMS Office in Yaoundé

These positions will contribute part of their time to the EIP and include:

Associate Director for Family Health: ACMS Associate Director for Family Health is an expert in public health, malaria, and quantitative research methodologies, and is a former MOH district supervisor. He supervises all family health personnel at ACMS including those responsible malaria prevention, the ProFam clinics, and hydrique disease prevention.

Sales Manager: ACMS Sales Manager manages a team of salespeople and coordinates national distribution of products.

IEC/Marketing Manager: ACMS IEC/Marketing Manager develops branded and generic communication campaigns and coordinates interpersonal communication activities such as theater caravans.

Doctor-Supervisor: ACMS Doctor-Supervisor for ProFam-franchised health clinics conducts monthly supervision, regular training and evaluation of the clinics in the network

Malaria Coordinator: ACMS Malaria Coordinator is responsible for all malaria projects.

Hydrique Disease Product Coordinator: ACMS Hydrique Disease Product Coordinator manages activities related to the promotion of ORS (ORASEL) and the safe water system (Sur'Eau).

Pharmacist/Logistician: ACMS Pharmacist/Logistician is based in Yaounde manages all procurement and overseas packaging and warehouse operations. As our resident pharmacist, he is also involved in obtaining approvals for new products.

Staff based at the HKI Office in Yaoundé

The Nutritional Program Officer (NPO) is a full time employee of the EIP and is responsible for all Nutrition related activities.

Other Field Staff

These positions will contribute part of their time to the EIP and include:

Accountants (6): One based within the Yaoundé Offices of each PVO Partners, and one in each of the 3 provinces. Ensures the production of monthly financial reporting, assists with budget tracking and compliance, and work on the billing and timely reporting for this project.

Drivers (6): One based within the Yaoundé Offices of each PVO Partners, and one in each of the 3 provinces.

At the US Headquarters of Plan, PSI and HKI: Each PVO Headquarters has designated a public health professional as technical backstop and point person for the EIP. They will also serve as contact person with the partner PVOs in the US. For Plan, Senior Child Survival Specialist, Pierre Marie Metangmo, MD, MBA, MPH and Child Survival Associate Laban Tsuma MD, MPH will be based in the US and will provide technical support and facilitate partner cooperation. Dr. Metangmo, who will dedicate 10% of his time project and serve as primary contact, has 20 years of professional experience internationally and in the US and Africa. Mr. Tsuma will dedicate 25% of his time to the project. Dr. Metangmo will conduct supervisory visits twice per year and Mr. Tsuma will conduct one visit per year to provide technical assistance and to meet with partners and stakeholders to determine their level of satisfaction with and inclusion in the project. For PSI, Program Manager Mary Warsh will act as US-backstop for the program at a 4% level of effort. Ms. Warsh brings over 10 years combined experience in health care delivery, marketing, and international development. For HKI, Acting Deputy Director of Nutrition Erin Dusch will use her experience designing, supporting and evaluating USAID-funded health programs to provide technical assistance to the project at an 8% level of effort. The technical backstops of the three PVOs will meet in person every six months, one month after each major report to USAID. The EIP Planning Committee will help to set the agenda for these meetings based on their experiences with the project in Cameroon, and the successes or problems expressed in

the reports. Dr. Metangmo will act as the US secretary of the three PVOs. As secretary, Dr. Metangmo will coordinate US PVO meetings, and will send minutes of the meetings to the EIP Planning Committee. The EIP Planning Committee will participate in the PVO meetings by conference call.

The EIP Coordinator will send a quarterly program report to Plan HQ Backstop by the 15th of every succeeding month. This quarterly report will highlight activities done in the previous quarter, successes and constraints noted, and the planned activities for the new quarter and needed technical assistance. The HQ Backstop will read the report and share a written feedback. This will allow timely and targeted responses to required technical assistance.

Financial Management: Plan demonstrates substantial financial management capacity through management of over \$300 million in project funds annually. PSI and HKI have agreed to abide by a detailed sub-grant agreement with financial and reporting requirement in line with standard practice for USAID implementing partners and any regulations required by USAID in the award to Plan, the prime recipient. The sub-grant documents ensure that the recipients agree to follow the cost reimbursement principles outlined by the Office of Management and Budget. Reports will be in accordance with the terms and conditions as set forth in 22 CFR 226. All partners have financial accounting, audit and control systems that meet USAID requirements, and the Plan Senior Grants Accountant will provide oversight to the project.

7. Training Plan (Table):

Training Plan

Training activities address both staff knowledge and motivation, as trained staffs are more likely to find satisfaction in their work. Training also improves the client-provider relationship, as clients feel more secure in seeking care from a highly skilled professional.

Type of training	Trainee	Trainer	Place of training	Frequency	Period				
					Y1	Y2	Y3	Y4	Y5
5-day IMCI/RBM training on facilitation skills (MOST)	30 members of future Provincial IMCI Training Teams (MOST team)	National IMCI trainers of MOH	Province	Once during year 1	X				
5-day IMCI/RBM training on supervision skills (MOST)	30 participants from MOH or private sector institutions	National IMCI trainers	Province	Once during year 1	X				
11-day IMCI/RBM training	24 Staff of District Hospitals, IHC and private health providers (ProFam)	Provincial IMCI trainers	Provincial hospital	One per district during years 2 and 3		X	X		
Refresher IMCI/RBM training through annual district workshops, annual provincial workshops and MOST	Staff at District Hospitals, IHC and private health providers	Provincial IMCI trainers	Duty Station, Itinerant, annual workshops at districts and province	Continuing MOST. Annual workshops at districts and provinces in years 2,3,4 and 5		X	X	X	X
Skills and methods for facilitative supervision	MOH supervisors at districts and provinces; ProFam Supervisors	MOH supervisors at national level	Provinces	Once during year 1; continuing	X	X	X	X	X
On methods for community mobilization and health and nutrition	Staff from local NGOs hired by the EIP	EIP staff (Plan, ACMS HKI) and consultants	Yaoundé and provinces	Once during year 1	X				

Type of training	Trainee	Trainer	Place of training	Frequency	Period				
					Y1	Y2	Y3	Y4	Y5
promotion									
Training on the organization of community-based health activities	Women-based CBOs	Staff from local NGOs hired by the EIP	Communities	Continuous	X	X	X	X	X
On the application of PD/Hearth	PD/Hearth facilitators (Local NGOs, CBOs)	EIP staff/ consultants/ MOH	Communities	Continuing		X	X	X	X
On community health and nutrition	CHRP; CDTI distributors	Staff from local NGOs hired by the EIP; HKI	Communities	Continuing	X	X	X	X	X
On the organization and management of community health activities and facilities (HIS/Financial Management)	COSA/COGE	EIP staff and staff from local NGOs hired by EIP	IHC	Continuing	X	X	X	X	X
Practical internships on the field implementation of IMCI/RBM	Senior medical and nursing students	ProFam and University staff	ProFam clinics, Yaoundé	Continuing		X	X	X	X
Training on LQAS (initial and refresher)	Staff at District Medical Office, EIP staff	Plan staff and consultants	Yaoundé	Continuing	X	X	X	X	X
Training on the community-based health information system	CHRP, CBO and COGE/COSA	Staff from local NGOs hired by the EIP	Communities	Continuing		X	X	X	X
Training on the facility-based health information system	Staff at district hospitals and IHC	EIP staff plus MOH provincial staff	District Medical Offices	Continuing		X	X	X	X
Growth monitoring/ Counselling/ ITN Retreatment	CBO Members, School Children	EIP staff, District Health team, Local NGOs	Communities	Continuing	X	X	X		
Community Case	CHRPs	MOST Team	IHCs	Continuing		X	X	X	

Type of training	Trainee	Trainer	Place of training	Frequency	Period				
					Y1	Y2	Y3	Y4	Y5
Management									
Training of Trainers on Nutrition (five days)	EIP staff, District medical Team, local NGOs	MOH/ HKI/ Consultant	Provincial			X	X	X	
Training on CSSA	All EIP Stakeholders	Plan staff (HQ)	Yaounde	Year 1	X				
Training on the Behave Framework	EIP staff, Plan staff, District medical Team, local NGOs, COSA	Plan staff (HQ)	Yaounde	Year 1	X				

8. Work Plan (Table):

WORKPLAN Plan/EIP

Major Activities	Year 1				Year 2				Year 3				Year 4				Year 5				Personnel
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Management and coordination																					
Meetings of the National Planning Committee	X		X		X		X		X		X		X		X		X		X		EIP coordinator
Meetings of the Provincial Implementation Committees	X		X		X		X		X		X		X		X		X		X		Provincial EIP staff
Meetings of District Coordination Meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Provincial EIP staff
Training and community health activities																					
5-day IMCI/RBM training on facilitation skills (MOST) for 10 members of future Provincial IMCI Training Teams (MOST team)				X																	MOH in collaboration with Plan Cameroon
5-day IMCI/RBM training on supervision skills (MOST) for 10 participants from MOH or private sector institutions				X																	MOH in collaboration with Plan Cameroon

11-day IMCI/RBM training for 24 Staff of District Hospitals, IHC and private health providers (ProFam)					X				X													MOH in collaboration with Plan Cameroon
Refreshing IMCI/RBM training using quarterly district coordination and semi annual provincial Planning meetings plus MOST continuous training sessions for Staff at District Hospitals, IHC and private health providers (ProFam)			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOST
Provincial Strategic Planning Workshops for C-IMCI				X	X																	EIP staff, MOH
District Operational Planning Workshops for C-IMCI					X	X																EIP staff, MOH
Training on methods for community mobilization and health and nutrition promotion for local NGO staff				X																		EIP staff and consultants
Training of CBO, CHRP and COGE/COSA					X				X				X				X					Local NGO
Operations Research (2 sub-grants)						X								X								Plan, MOH
Operation of patient referral				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	CHRP, CBO

Operation of MOH supervision				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH
Operation of community health promotion activities (PD/Hearth, VAS, IFA, Health and Nutrition Action Week, etc.)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	CHRP, CBO, COSA/COGE
Dissemination events and Visits																					
Annual IMCI/RBM Technical Update Workshop				X				X				X				X				X	National IMCI Working Group in collaboration with
Plan West Africa IMCI/RBM Conference				X				X													Plan
CCM Visit to the DRC by Central MOH												X									3 PVO/ MOH AWARE, BASICS III
Monitoring and Evaluation																					
Baseline study (LQAS, HFA)	X																				3 PVO/ MOH
Preparation of DIP		X																			3 PVO/ MOH
Midterm evaluation										X											3 PVO/ MOH
Final evaluation																			X		3 PVO/ MOH
District monitoring using LQAS and HFA			X		X		X		X		X		X		X		X				MOH Plan
Operation of the Community HIS					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Local NGOs
Annual reports to USAID					X								X				X				3 PVOs
Support to policy making and fundraising																					
TA to MOH for policy making and fundraising			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Plan, PSI/ACMS, HKI

PVO Headquarters backstop																				
Visit of PVO HQ staff to EIP	X		X		X		X		X		X		X		X		X		3 PVOs	
Meeting of HQ backstops	X				X				X				X				X		X	3 PVOs
Coordination with USAID WARP																				
Meetings with USAID WARP	X		X		X				X				X				X		X	Plan

WORKPLAN ACMS/EIP

Activities	Year 1				Year 2				Year 3				Year 4				Year 5				Responsibility
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
DIP Writing			X																		
Communication and use of mass media																					
Interpersonal communication (IPC) provided by sales promoters				X	X	X	X	X	X	X	X	X	X	X	X	X					Sales promoters
Produce new radio spots on Orasel						X															Water borne diseases coordinator & Com.Coordinator
Produce radio spots over Correct and timely use of ACT home kits					X																Malaria Coordinator & Com.Coordinator
Air radio spots on Orasel						X		X		X		X		X		X					Com.Coordinator
Produce new Radio spots on Sûr'eau/Waterguard			X																		Water borne diseases coordinator & Com.Coordinator

Activities	Year 1				Year 2				Year 3				Year 4				Year 5				Responsibility
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
Air radio spots on Sûr'eau/ Waterguard			X	X	X		X		X		X		X								Com. Coordinator
Produce new Radio spots on IPT				X																	Malaria coordinator & Com. coordinator
Air radio spots for ITN promotion			X	X	X			X	X			X	X			X					Com. coordinator
Produce "On sale here" stickers for Orasel								X													Com. coordinator
Air radio spots on IPT and ACT			X	X	X			X	X			X	X			X					Com. coordinator
Develop and produce posters over the importance and use of IPT and ACTs				X																	Com. Coordinator, & Malaria Water borne diseases coordinator & Com.Coordinator
Printing Posters on Orasel				X																	
Development and production of the CBO's training guide for ACMS products					X																Com. Coordinator
Development and production of 'Fighting malaria' flipchart						X															Com. Coordinator
Develop and produce the "New Mother's guide" booklet			X	X																	Com. Coordinator
Production of Calendars				X				X				X				X					Com. Coordinator
Caravan events					X	X	X	X	X	X	X	X									Com. Coordinator
Training and community health activity																					
IMCI training of ProFam supervisors					X																MOH/PLAN
Training of Local NGOs & CBOs on ACMS products use				X	X	X	X	X	X	X	X	X	X	X	X	X					Sales Promoters
Training of ProFam providers					X				X												MOH/PLAN
Continuous ProFam supervision					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	ProFam supervisor
Practical training to medical and nursing students																					

Activities	Year 1				Year 2				Year 3				Year 4				Year 5				Responsibility
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
Subscription of ACMS/ProFam-University agreement				X																	ACMS Permanent Secretary
Practical internships of Medical students							X	X	X	X	X	X	X	X	X	X	X	X	X	X	ProFam supervisor
Dissemination of events																					
PSI posts Lessons learned on The Wave					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	ACMS Permanent Secretary
Monitoring and evaluation																					
Quarterly report to PLAN	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	ProFam supervisor
ProFam network monitoring using IHFA	X								X								X				ProFam supervisor
ProFam network monitoring using mystery clients					X								X								ProFam supervisor
Annual reports to PLAN					X				X				X				X				ProFam supervisor
Midterm evaluation										X											BUNDLE (EPC)
Final evaluation																				X	BUNDLE (EPC)

WORKPLAN HKI/EIP

Major Activities	Year 1				Year 2				Year 3				Year 4				Year 5				Personnel
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Baseline surveys	X	X																			NPO
DIP Writing		X	X																		NPO
Operational research (zinc, nutrition education strategy)				X	X																Consultant/NPO
Policy Advocacy (zinc)							X	X	X												EIP
Nutritional input to IMCI curriculum				X																	NPO

Development of nutrition training curriculum					X																NPO
Development of nutrition education strategy, material and messages					X					X					X						NPO
Training of trainers						X				X				X							NPO
Training of CDTI distributors						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	OPO
Organization of vitamin A supplementation campaigns						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	OPO
Establishment of National Nutrition Working Group					X																NPO
Nutrition working Group meetings								X				X				X				X	NPO
Semi annual partner Meeting (HKI person/US)		X		X		X		X		X		X		X		X		X		X	HKI backstopping
Supervision and monitoring				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		NPO/OPO
Dissemination of studies results', lessons learned and best practices						X			X				X						X		NPO

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ⁱⁱ Global Fund. 2003. Cameroon CCM Proposal: Resubmission (March 2003). Global Fund, Geneva.

ⁱⁱⁱ Anuraj H. Shankar, Blaise Genton, Richard D. Semba, et al. Effect of Vitamin A Supplementation on Morbidity Due to Plasmodium Falciparum in Young Children in Papua New Guinea: a randomized trial, the Lancet 17, Vol 354, No. 9174 pp 203-209, 1999.

^{iv} Black R et al. 2003. Where and why are 10 million children dying every year? Lancet 2003. 361: 2226-34.

^v UNDP 2003

^{vi} Profiles analysis 2002

^{vii} DHS III 2004

^{viii} PRB. 2004. Health inequalities: Data on women and children in 53 developing countries. Population Reference Bureau, Washington DC.

^{ix} CIA World Fact Book entry for Cameroon 2000, World Bank Development Report 2003

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